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The American Hospital Association

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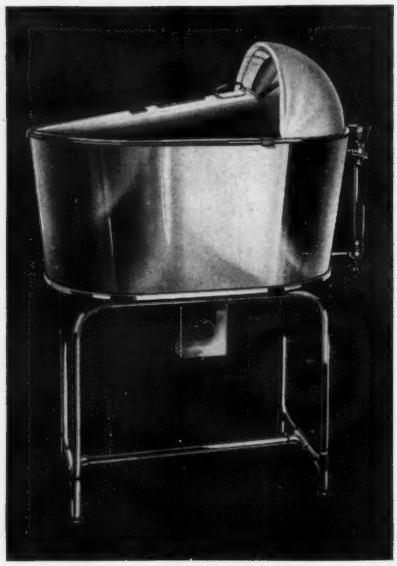

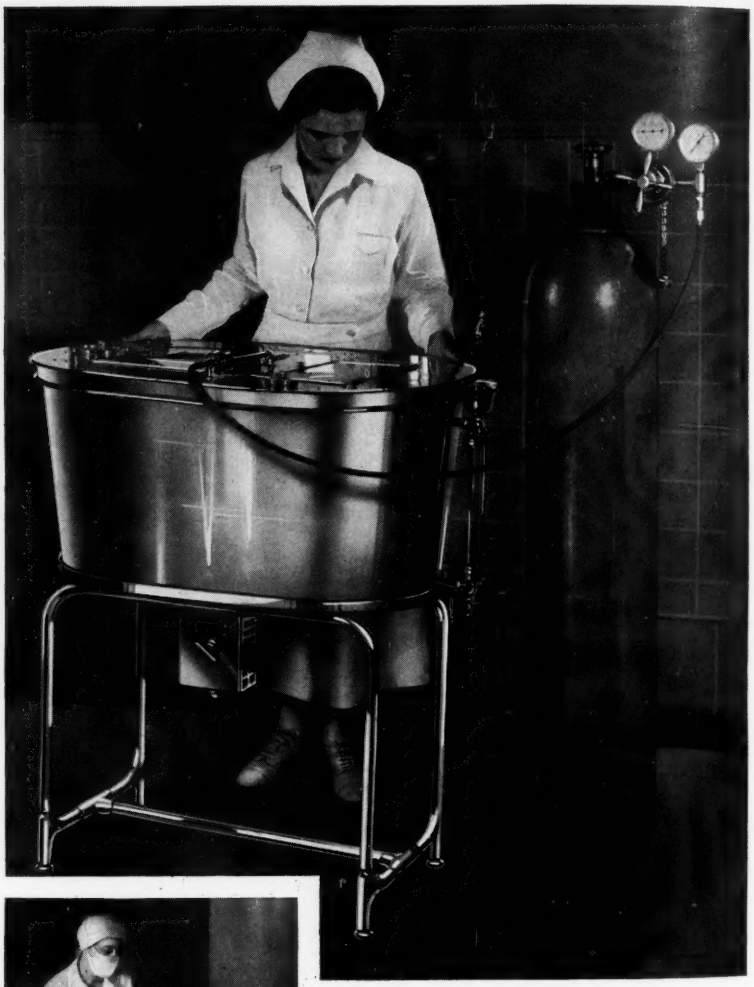

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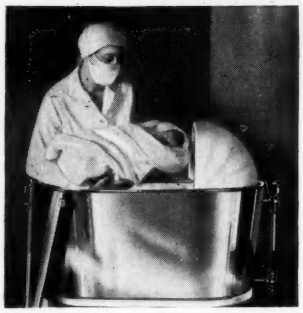

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HOSPITALS

THE JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

VOL. 14 MAY, 1940 No. 5

Public Relations of the Hospital

E. H. L. CORWIN, Ph.D.

THE public relations of the hospital are many and varied. As a large purchaser of milk, coal, cotton, machinery, meat, drugs, bedding and wearing apparel, it has a full quota of complicated internal and external relationships; of conflicts with various federal and state laws and regulations; of ethical strains with certain types of board members and the mercantile "friends of the institution"; and of intellectual stresses as to the relative advantages of free and independent buying as against cooperative efforts of one kind or another.

As an employer of labor, it has all the tenderness of noncompetitive benevolence, all the heartaches of economic impotence, and all the horrors of strikes, walkouts, or sitdowns, actual or threatened.

As a collector of specimens, it has occasional difficulties with undertakers, with the anatomical departments of medical schools, and with law interpreters of one kind or another.

The Author

● Dr. E. H. L. Corwin is the Executive Secretary of the New York Academy of Medicine, New York City.

As a teaching institution, it has all the problems and worries and responsibilities of a private coeducational boarding school—without its income, however. It has its friendly tilts with the state educational authorities with respect to the curricula of nurse training schools or with respect to housing facilities; with the American Medical Association concerning internships and residencies; and with the American College of Surgeons regarding arrangements or equipment, or the occasional slight deviations of some members of the professional staff from the stiff and uncomfortable path of the much maligned "horse and buggy" virtue.

As an administrative unit, it has responsibilities toward the numerous official and voluntary bodies of a supervisory, stimulative, cooperative, correlative, auxiliary, ancillary, fraternal, pa-

Presented at the Annual Meeting of the New England Hospital Association.

ternal, sororal, and maternal character as well as toward the courts, the departments of health, insurance companies, hospital prepayment schemes, community chests, visiting nurses' associations, family welfare societies, churches, and toward potentially charitably-inclined individuals or Foundations.

And, finally, as a Good Samaritan, the hospital has relationships with sick people of all types and temperaments, of many races and creeds of various degrees of religious emotion and prejudice, and of all ages and sexes. It deals with the wives and husbands of patients, with their brothers, sisters, mothers and fathers, cousins, and other relatives and friends; it deals with blood donors, and ambulance chasers, bad debts and dunning agencies, lawyers and courts; it deals with the educated and the ignorant, the wise and the foolish; normal individuals and the insane. In other words, the whole world around us, with the milling multitudes of the teeming city and the cantankerous and slow-witted cranks of the countryside, comes within the orbit of the hospital. Here and there the hospital has a lawsuit on its hands. Here and there it runs afoul of organized medicine. Here and there it is charged with unfair competition, with advertising, with taking away patients from doctors and treating them at high price in the out-patient departments. Here and there the hospital is accused of incompetent and wasteful management. It is quite a lively merry-go-round, this hospital world of ours.

The Creation of Community Good Will

No one can exhaust the discussion of hospital public relations within the compass of a short article; the subject is as broad as community life itself, and as ephemeral as individual and collective psychology. The broad purpose of public relations is, of course, the creation of good will between the hospital and the various elements of the community it serves. There are many ways to achieve this in one measure or another. I shall not try to enumerate them all. Many of them are trite and well established. You will find them listed and discussed in any standard manual. None, however, should be neglected. You should never take anything for granted. The average mind is so constituted that it learns only by repetitive process and your employees are of the average run of humanity. It is necessary, therefore, to keep on repeating that patience, consideration, and courtesy are basic requirements of every one in the hospital ménage, from the highest to the lowest, and that absence of these essential traits of personality make-up will lead to unconditional dismissal.

Remove all other unnecessary irritants, such as the nonchalant, so-called "professional," attitude of the admitting office. Install attractive hospital hostesses. Do not let a brusque or inexperienced clerk or a dour nurse be the first person a patient encounters on arrival at the hospital. From the start have the matter of charges to patient or his family explained clearly and precisely so as to avoid any future misunderstandings. Do not allow the good food you are buying to be spoiled by incompetent cooking or sloppy serving; this unfortunately happens altogether too often. Better close up your out-patient department than suffer it to become a medical "soup-kitchen" with all its blight to medical standards and to the health and self-respect of its clients. If you cannot do anything else with it, restrict it to the four purposes recommended by the British:

1 Care of accidents and emergencies

2 Consultations requested by neighborhood practitioners

3 Special treatments which can only be given at the hospital

4 Follow-up and treatment of discharged hospital patients who require special supervision

The Purpose of Good Hospital Public Relations

Let me stress again that the purpose of good hospital public relations is to establish a friendly *modus vivendi* with all the elements of the community in order that the hospital may be in a position to render most effective service and that it may obtain without undue difficulty the necessary support for the maintenance of such a service. This calls for a thorough arousing of interest in the hospital. With respect to this, it must compete with many other community, national, and world events claiming the attention of the public, and to be successful it must employ methods which will call attention to the hospital even amidst the turmoil of political and business strife. No one in his senses can imagine that hospital news can supplant interest in the dramatic events of the War and the issues it has raised, or in the developments of a presidential campaign or in the doings of the world of sports, but, if skillfully carried out, it can obtain secondary consideration. After all, at our dinner tables and at club and other gatherings we do not discuss war and politics all the time, nor even football games or the World Series. Here is the hospital's opportunity.

Testing the Patient's Relations to Your Hospital Service

Various businesses and industries test their customers' reactions from time to time. Why

shouldn't the hospitals do so, singly or jointly? Why not submit some well-timed questions to various groups in a manner similar to the Gallup polls and endeavor to publish the summaries in the local press? This will concentrate the public's attention on some important hospital problems. Should the summaries fail to get into the newspapers, the questions submitted would nevertheless be discussed by those who received them with their relatives and friends. One of the purposes of such polls would be to focus discussion on vital hospital subjects and to make the public realize that many problems occupy the minds of hospital administrators and trustees, and that in the solution of these problems they wish to be guided by intelligent and informed public opinion.

Creating Ethical Publicity

Another well-known method of arousing public attention is by creation of events. It is not every day that the King of Siam comes to America for a cataract operation, or something else of this kind calls attention to the high esteem in which our hospitals and our medical profession are held the world over. Event-creating publicity should be attempted with a great deal of circumspection, for it is very easy to overstep the proper bounds of propriety and of good taste, and it may do more harm than good to the hospitals. Of much greater value is the skillful release of interestingly prepared current material or of historical facts relating to certain institutions, individuals, or occasions.

Dr. John Green's Essay on "City Hospitals"

I should like to remind you that the first American contribution in the field of hospital construction was made in Boston in 1861 by a Dr. John Green, Fellow of the Massachusetts Medical Society, when he published his essay on "City Hospitals."[1] At that time hospitals were still being built in accordance with the precepts of the French Academy of Sciences promulgated in 1788. Around 1860, a committee of the City Council of Boston advertised for a plan for the municipal hospital and offered a prize for the best plan submitted. The prize was awarded to John Green who in the preface to his treatise says that the plans which he submitted "are in no sense a copy of any building in the United States or Europe or elsewhere, but are believed to combine the most valuable features of the hospitals in France, Great Britain, and Germany." His is verily a remarkable treatise and for the purpose of ascertaining your opinion as to whether historical facts could be utilized for hospital "publicity" purposes, I shall proceed to give you an outline of his ideas which, to my knowledge, embody the most advanced hospital thought of the time and deserve to be better known than they have been.

To begin with, the author points out the need of a central location of a hospital for acute diseases; it should be easy of access to patients, physicians, and students, and the site should be selected with due regard for its cost, as well as the purity of air and good drainage. He then proceeds to differentiate between patients acutely ill for whom a hospital within the city limits is needed and those who suffer from infirmities or chronic diseases, the convalescents and the insane for whom provisions should be made outside of the city limits. He stresses the point that a hospital for convalescents in the country should be connected with and be under the same general direction as the hospital of which it is a branch.

In planning a hospital, future enlargement should be anticipated and the hospital should be so designed as to make such extension possible without undue expense. He refutes the then popular notion that a hospital is a "sanitary evil" to the neighborhood by pointing out that experience in the most crowded cities of Europe is sufficient evidence to the contrary. He would protect, however, the neighborhood against unsightly and repulsive objects by erecting the hospital buildings around a central court, thus effectively cutting off the patients from the view of neighbors and passers-by.

In designing buildings he stresses the importance of providing direct sunlight, which he recognizes as having beneficial influence on the sick, and suggests that the wards be so placed as to admit both the morning and afternoon rays. The few patients who suffer from diseases of the eye or of the nervous system should be accommodated in moderately dark rooms. To guard against the untoward influence upon the patients of the noise on the streets, particularly patients who are not inured to it by a previous residence in the city, he suggests double windows. The ventilation is to be supplied through a complicated system of flues, vents, fireplaces, etc. Proper ventilation will guard against "hospitalism," by which was meant, the spread of infections which take place within the hospitals.

He maintains that "epidemic diseases are not the necessary condition of the association of the sick, even in somewhat crowded wards." He refers to an institution, near Boston, where no epidemic has ever appeared, and "at all times wounds heal in its ward as promptly as in private practice in the most rural districts." This unusual condition of the pre-aseptic era he ascribes to the

[1] John Green. "City Hospitals" (66 pages and illustrations), Boston, Little, Brown, and Company, 1861.

peculiarly exposed situation of the hospital buildings.

To guard against overcrowding of the hospital and to insure its utilization by only those who are acutely ill, he suggests the organization of out-patient departments, because of the extreme economy of this form of treatment and the opportunity it affords for "quick yet accurate diagnosis" and for "continuing the treatment of convalescents, who may thus be discharged from the wards much sooner than would otherwise be provident." Among the diseases which can be most successfully treated in this way he mentions venereal and skin diseases, almost all of the ophthalmic and aural conditions, and a great variety of medical and surgical diseases which "though they do not confine the patient to his room are nevertheless productive of much suffering." He provides for a layout of the out-patient department consisting of two suites on the first floor. Each suite includes a consultation room, an ante-room, and two waiting rooms for the reception of patients of the two sexes. The consultation rooms are provided with seats of sixteen feet in diameter for fifty students each, and have a circular arena, for the physician and patient. Provision is made for parlors for the visiting medical officers and house pupils and accommodation for students and visitors. There are waiting rooms in connection with the drug dispensary.

He maintained that in the hospital "a proper classification of patients is of the highest importance." The separation of patients by sexes in the medical, surgical, and obstetrical departments is insufficient. Many of these classes should be subdivided. The contagious diseases should be treated separately. Venereal disease patients should not be in the same wards with "other surgical cases." The need of separating ophthalmic and neurological cases has already been mentioned. Single rooms are of invaluable aid in managing nervous patients who "may suffer intensely from the ordinary sounds of even a well regulated ward." He was the first to point out that some of the patients required separate rooms either for their own comfort or that of others, and suggested that every ward should have connected with it a room for the dying or delirious patients, and a part of the hospital with separate rooms should be set apart for the "foul" cases as well as for the noisy and unmanageable ones. He also recommended a few single rooms to be devoted to private patients—"strangers of means sufficient to defray the expenses of their sickness, but without home or friends in the city." He likewise advocated separate rooms for parturient women. In spite of the considerable number of separate rooms which the plan provides, the great majority of patients are accommodated in common wards where they can be "more advantageously treated."

The wards should not accommodate more than 30 patients. A ward of this size can be well supervised by one head nurse "residing constantly in the ward or in an adjacent room," and two assistants for day and night service, besides other occasional help. A small kitchen or workroom, bathroom, and at least two water closets should be attached to each ward. He provides the hospital with a bathhouse for hot, cold, and vapor baths and a separate accommodation for sulphur, saline, and other medicated baths. In seaport towns he suggests the pumping of sea water directly from the harbor. Apparently only pleasure resorts, like Atlantic City, have thus far followed this suggestion. The most convenient location for the bathhouses is near the laundry, for the same fires and hydraulic apparatus may be used for both departments. The theater for post-mortem examinations forms an indispensable part of every well-appointed hospital; an autopsy of every patient dying in the hospital should be made for the verification and correction of diagnosis. The rooms adjoining the autopsy room are to contain vaults for the reception of bodies and for the preparation of them for burial. All the rooms should be ventilated by maintaining a constant current of air through them, by the draught of a fire in a large chimney, or by some other motive power.

The dwelling houses for the medical director, resident physicians, superintendent, and interns; a lodge for the porter, living quarters for servants; a kitchen and dining room and storerooms are all provided for within the confines of the hospital.

One interesting reason given in support of a municipal hospital is that it affords greater freedom in the utilization of patients for study and research than is possible in an ordinary charitable hospital. Although all hospitals are essentially charitable institutions and "the welfare of the patients must ever hold the first place in the minds of their founders, nevertheless we must not lose sight of the fact that they are also great schools of clinical observation and instruction, and have thus, perhaps, rendered their most important service to mankind . . . In arranging a new hospital therefore, we ought to offer to physicians, and students in medicine, every facility for study consistent with the comfort of the patients."

I do not know whether the Boston City Hospital, when it was built, incorporated all the fea-

tures of the prize essay above described, but irrespective of whether or not it incorporated all the suggestions made, the essay marks the beginning of the modern era in hospital thought. Would not historical facts of this type, when properly dished out, make interesting pabulum to intelligent citizens? There is a great wealth of material of such and similar character.

Stories of Human Interest

Then, the files of every hospital social service department abound in stories of genuine human interest, not necessarily tear jerkers, but profoundly moving accounts of constructive medical and social endeavor, of scientific achievement in the face of adverse social environment, and oftentimes in spite of defective heredity. The hospitals have a grandiose story to tell which, unfortunately, is frequently unappreciated by the hospital authorities themselves. Everyone in the hospital organization is too much absorbed in his immediate task to give time and thought to analysis. Even our hospital statistics do not receive the care they deserve, not only from a social viewpoint, but from the standpoint of the individual institution. In the annual reports most valuable social and pathometric data are published without any correlation and without comparisons with former years, or with similar data of other comparable institutions. In the Annual Report of the Peter Bent Brigham Hospital for 1922, after reviewing in a most informative manner the experiences of the hospital for the year, Dr. Harvey Cushing added:

> "Figures such as those which are given in the foregoing table, however, lose their chief interest and value unless they can be utilized as a means of comparison with the year's work of other teaching hospitals. All who deal with such statistics fully realize that they can be made to show almost anything that one desires, and unless there is some agreement between hospitals as to common standards of tabulation they can be very misleading . . . Not until the clinical chiefs of our major hospitals come to share with the administrator an interest in these annual reports may we expect to have any uniformity in the methods of reviewing from year to year the results of our therapeutic efforts in the operating room and at the bedside. Without uniformity, any comparison of these results is impossible, though it was for these ends that the hospitals were really established."

The Pooling of Statistical Information

Through some appropriate agency, each community should pool all available statistical information pertaining to the care of the sick, whether it be of administrative, financial, or scientific character. I do not know of anything that could be of greater usefulness as a source of interesting messages to the public on an endless variety of subjects on the work of hospitals than such a statistical service.

Trends of Unit Costs

Cyclical trends of unit costs with running comment would make a fascinating story and would go a long way to help in the explanation of variations in costs and of mounting hospital expenditures. The mind of the public must be disabused of the prevalent notion that the rise in costs is due to the extravagant and fanciful notions of physicians, surgeons, and hospital planners. There are those who maintain that we have built our hospitals in too great units and that we have carried the size beyond the point of where the law of diminishing returns sets in. Some critics believe that the amount of space which our new hospitals devote to ancillary services is much too great in comparison with that allotted to the physical accommodation of the patients themselves. A calculation made about a decade ago by Edward F. Stevens of Boston, the dean of the hospital architects in the United States, based on an analysis of a considerable number of hospitals of various types and sizes which were completed about that time in several cities, gave a measure of support to this opinion, for it indicated that only 21 per cent of the available space was given over to actual accommodation of patients. Some maintain that our modern hospitals are too lavish in their appointments and extravagant in administration cost. Others point out that by building special hospitals or institutes, in connection with our stupendous medical centers, we are reverting to the eighteenth century idea of the pavilion system in a glorified form.

While there may be some truth in all of this, it must be stressed that what we have now came, on the one hand, in response to the exigencies of medical progress and the evolution of scientific technique, and, on the other hand, to satisfy the ever-increasing demands for luxury and comfort on the part of the public. Nevertheless, it should be admitted that at times we have gone too far and that some of our institutions are evolutionary excrescences of an opulent and glorious age which is gone and buried. In spite of an admittedly temporary flush, those responsible for the work and management of hospitals have never lost a sober sense of reality, and the following statement recently published may, with just pride, be repeated on every occasion, to wit:

"There is almost no degree of inconven-

ience, incompetence, mismanagement, inadequacy of buildings, organization, personnel, and equipment which cannot be overcome by exceptional devotion, resourcefulness, and skill on the part of physician and nurse. It is equally important for the public to understand that the likelihood of uniform delivery of good medical care to the sick in hospitals depends largely upon the competence of administrative organization, the qualifications of the professional personnel, and the wise and just determination of policies."

In the final analysis, it is not the buildings and equipment, indispensable as these are, that make a hospital; it is the skill and devotion and sense of responsibility of all concerned that count.

The Joint Responsibility For the Welfare of the Patient

If I were asked to describe briefly the concept of the modern hospital idea, and wherein it differs from the concepts of the past, I would say that it lies in the conscious effort which is being made to achieve the ultimate object, namely, the welfare of the patient, through a joint responsibility of all concerned. It is to this end that the present form of organization of professional and executive staffs has been effected, the structural adaptation of the environmental facilities made, and the interest of outside forces enlisted. It is the present-day teamwork and all that has been done to render it possible that distinguishes the modern hospital from its predecessors. Toward this cooperative effort and joint responsibility all the forces within and without the hospital are being brought into play. Hence, the growing importance of the hospital in the community and its ever-widening educational, civic, public health, and social welfare contacts and responsibilities. Whether we have reached the ideal, I shall not attempt to say. On general principles, I suspect we have not.

Questions Engage the Earnest Thought of the Hospital Field

With the rest of the world, the hospital is now standing at the crossroads. The financial débâcle which has overtaken the world has temporarily suspended the building of new hospitals. The time, therefore, is particularly ripe to give full consideration to the entire field as we see it today and to appraise the evolution to date, with a view to directing it more consciously and more uniformly than has been the case in the past. Have we over-hospitalized ourselves, particularly in the cities? Have we gone too far in advising the public to resort to hospitals? Have we provided a sufficiently large number of institutions for the care of the chronics and the convalescents? Has the integration of the dispensary with the hospital proceeded along the line of best medical thought? Are our hospitals making the most of their opportunities for the advancement of medical science and the improvement of general medical practice? Are we making available to the general public the facilities which the hospitals can give extramurally? Has there been a sufficient linkage between the hospitals and the public health movement or preventive medicine? Can the modern hospital organization make possible a larger participation in hospital work on the part of "family physicians"? Is the recent movement for social insurance against the exigencies of illness going to exert a beneficial or harmful influence on the hospitals? Have we gone too far or not far enough in providing hospital care through taxation? If there should be an extension of government support for the care of the sick, how should it be organized?

These are but few of the questions to which earnest thought must be given on the part of all of us interested in the evolution of social and medical ideals and institutions. This is the domain of public relations.

The Bacon Library and Service Bureau

The Bacon Library has in all probability the most extensive and valuable collection of hospital literature that has been assembled. It is constantly adding rare and interesting volumes of hospital texts both by purchase and through gifts of friends of the Library who wish to have a repository for hospital literature which they have in their possession and for which they have no further use.

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Packages should be addressed to the Bacon Library, American Hospital Association, 18 East Division Street, Chicago, Illinois.

Budgets and What to Use for Money

GUY J. CLARK

A BUDGET is a statement of anticipated income and expense. It has always been, and perhaps always will be, difficult to control expenditures whether it be for an institution or an individual. The present day requirements are, as a rule, greater than income will permit and as a consequence if a method of control is not provided, financial difficulties will result.

The large daily newspapers in metropolitan areas recognize the importance of budgets for individuals and provide a column for advice on preparation of budgets based on monthly income.

The preparation of the expense portion of a budget should be the combined judgment of the hospital administrator, the persons in charge of the various divisions of the hospital, and the governing board. Too often budgets are prepared with adequate provision made for expense, but without due consideration and thought to income. Many times budgets are balanced at the time of preparation by wishful thinking from the income side rather than real anticipation.

Factors in the Preparation of the Budget

The development of a budget by the simple procedure of using expense figures for the preceding year, disregarding the fact that a deficit may have occurred, provides a document that is of no value. If the budget is prepared to be useful to the management as a control of expenditures, the administrator, other executives, and department heads must give consideration to the following factors in the preparation of it:

The financial status of the hospital at the time the budget is prepared, which should include the amount of accounts payable as well as capital obligations

The general economic situation in the community

The possible change in the economic situation and the possible affect upon salary schedules and commodity prices

Prospective changes in hospital bed capacity in the community and how it may affect the occupancy of the hospital

The Author

● **Guy J. Clark is the Executive Secretary of the Cleveland Hospital Council, Cleveland, Ohio.**

The probable income from pay patients, income from endowment, governmental agencies, community funds, and other contributions

If adequate control is to be maintained, the administrator must make frequent reference to the budget when making decisions regarding expenditures, and must be sufficiently informed on current income to be in a position to say "No" when the occasion demands. The administrator should hold the department head responsible for the operation of a given department within limitations of the amount allowed, and in order to stimulate interest in doing so, the administrator should provide a monthly statement showing how actual expense compares with the budget. There must exist a complete understanding between the administrator and department head, that adjustments will be made when circumstances warrant, but due consideration will be given to the units of service rendered.

The Budget as a Tool of Management

The information gained from a well prepared and thoroughly understood budget enables the hospital administrator to coordinate and control the various activities with the highest degree of efficiency. A budget is a tool of management and is only as effective as the hand that wields it. If the executive and department heads assume a self-satisfied attitude after the completion of a budget and proceed to make no further use of it, the result is likely to be one of disappointment.

A hospital budget is no different in principle than one prepared by private industry. Many voluntary hospitals have capital indebtedness which they are required to pay from earnings and in that respect are comparable to industry, but are not faced with the requirement of distribution of earnings to stockholders. Often times in the preparation of a budget, the hospitals do not give

as thorough attention to their obligations as is warranted.

When the Hospital Incurs Its Deficit

The income of hospitals is subject to frequent fluctuations just the same as that of a private enterprise. A hospital that operates at a deficit year after year, does so for one of several reasons: (1) they either miscalculated the income, or have ignored expense; (2) they have assumed an obligation of rendering service to needy citizens of the community, which obligation should be assumed by the community as a whole; or (3) their rate structure has not been properly established to provide sufficient income.

I personally do not know of any substitute for money. The average vendor has always been liberal in the extension of credit to voluntary hospitals. Certainly a hospital cannot assume that by taking advantage of liberal credit and thereby continuously increasing the amount of accounts payable, that credit is a substitute for money. It most assuredly can be agreed that the ultimate result of liberal credit is an obligation that can only be met by money. If a commercial organization follows the practice of operating on credit without proper provision for meeting such obligation, the eventual result is bankruptcy.

Voluntary hospitals in the past have, because of community service, been fortunate in securing assistance from various sources by an appeal to the interested citizens when credit could no longer be obtained. Voluntary hospitals, in my opinion, cannot anticipate receiving in the future such support in the way of cash contributions from philanthropic minded individuals for the liquidation of accumulated accounts payable.

Sound Business Procedures

What can hospitals use for money? If you will grant that there is no substitute for money, then the voluntary hospitals must recognize the obligation of reorganizing their method of operation so that they can carry on their functions and still operate within reasonable limits of their cash income for any particular year. They must either follow the policy of limiting expense to the bare necessities, or develop ways and means for increasing their income from different sources, if they are to continue to operate as they have in the past. Sound business procedures must be adopted, such as: (1) proper accounting methods, so that they are fully familiar with the cost of the various divisions; (2) adoption of sound purchasing policies and the control of inventory; (3) sound admitting policies and a recognition on the part of hospitals of the importance of well trained and well qualified admitting officers, with sufficient time at their disposal to accurately determine the ability of patients to pay for the service which they receive.

Importance of Evaluating the Costs of Operation

In many instances hospitals have not been sufficiently acquainted with the cost of operation to develop proper rate structures between different types of service which they render, and perhaps to some degree the hospitals have themselves to blame for failure to educate the public to the point that patients would assume the obligation of paying for hospital service in an amount sufficient to more nearly meet the cost of operation. Too often it has been the case of rate structures having been developed on the basis of what the individual hospital, or hospitals as a group, thought the traffic would bear rather than rates which should be established to provide income to meet expense.

Why Community Service Should Be Properly Recorded

Often the public as well as public officials are not thoroughly familiar with the reasons why hospitals are in financial difficulties, and this may be partially accounted for by lack of proper recording of community service. To some degree there has existed considerable hesitancy on the part of hospital officials to make concerted effort to acquaint governmental officials with their legal responsibility for payment to voluntary hospitals for the care of the indigent sick. To a greater degree than has been the practice in the past, hospitals must through their local and state organizations keep the elected officials acquainted with the amount of service which they render to citizens of their community who are unable to pay for their care, and thus place the responsibility where it rightfully belongs. The payment of hospitalization of the indigent sick should be, in my judgment, confined as closely as possible to local governmental units rather than an obligation to be assumed by the Federal Government. The voluntary hospital certainly has no right to assume an obligation of rendering service to indigent persons in the community at the expense of the vendor. They certainly do not have the privilege of providing this service with merchandise which does not, in a true sense of the word, belong to them.

Voluntary hospitals have been so organized that income from the care of patients is inadequate, in the majority of instances, to meet the cost of hospital care. A certain proportion of patients pay the cost of hospitalization, and to a limited extent certain patients pay an amount somewhat greater than actual cost. Other groups of patients are admitted paying less than the cost of service,

while a third group pays nothing for their hospitalization, the cost being covered by one of three methods: (1) by private charity through the Community Fund or through hospital endowment; (2) by payment from governmental agencies of public charity; or (3) by the use of any excess paid by private patients. All three of these sources of revenue have been uncertain. Public and private charities contributed varying amounts, while the economic cycle has often seriously reduced income from private patients at a time when such income was seriously needed.

Hospitals are in a transitional period, during which development must be studied, anticipated and intelligently directed in order that the present organization for voluntary hospitals may continue to give the best possible hospital service to the community.

Establishing the Rate Structure on the Basis of the Cost of Rendering Service

If additional funds are to be secured, it will require a considerable effort on the part of the voluntary hospitals and, perhaps, the most immediate expectation is a study of rate structure on the theory that rates should be established on the basis of cost of rendering service. There are a great many persons in any given community who are in a financial position to pay at least cost for their hospital care, but are provided service at less than cost because rates have been established without proper study and consideration.

The possibility of increased endowment is considerably less today than were the prospects prior to the depression years. Those hospitals with considerable endowment are experiencing a decreased income from that source.

Role of the Hospital Service Plans in the Hospital Income

The development of hospital service plans to the point where they cover a considerable percentage of the total days of service, changes considerably the source of the financial support of hospitals. Hospitals operating in a community where there is a group hospitalization plan, and where there is considerable coverage by private insurance companies, should keep themselves fully advised of the probable number of persons in the community that have such coverage for hospital care. A great many of the persons who have protected themselves by subscribing to these plans, do so under the assumption that sufficient funds will be provided to meet the actual cost of hospital care, as the development of the insurance principle was predicated on the theory that the subscriber would be in a position where his hospital bill would be paid, and presumably in the majority of instances the cost of such care would be met.

Because the insurance idea for hospital care is in the development stage, it is particularly important that rates charged be at least the cost of hospital service, in order that in developing actuarial data in regard to premiums charged by insurance companies, the true cost would be used by the nonprofit hospitalization plans as well as the private insurance companies. If the rates established for the various types of accommodations are less than cost, the private insurance companies, particularly, will base their rates on present established rates in a given community, and it can be rightfully assumed that in many instances these rates are less than the true cost to the hospital. It is equally true that hospitals must develop their rate structures on a basis of at least cost, to a greater proportion of their patients if they are eventually to be in a position of paying for capital indebtedness as well as accumulated current accounts payable.

Rate structures for service rendered to patients who are a responsibility of private industry, should be adequate to pay the cost to the hospital of rendering such service, as private industry should not expect the voluntary hospitals to render service to their employees at less than cost.

Hospitals should give some consideration to control of admission of free patients and part-pay patients in relation to the amount of income available from the sources from which they expect to receive compensation for service rendered to these patients. A policy should never be adopted, however, that would so restrict admissions that any emergency patient would ever be refused admission.

Pertinent Questions Which the Hospital Must Decide

Can the voluntary hospitals expect the general public to donate funds for operating expense when and if a large portion of the population has protected themselves with a plan whereby their hospital expense is either fully or partially covered?

Should the hospitals have their rate structures for the various types of accommodations below the cost of providing such service, when the patient receiving such service has taken the proper steps to assure himself of reimbursement for hospital expense, or to have his bill paid by a service association?

Should hospital rates be based on actual cost, or should they be developed on a basis that income from private, semi-private and ward accommodations would equal the average per capita per diem cost?

Should rate structures be so developed that the income from private, semi-private, and ward accommodations either from the patient or governmental agencies, plus income from endowments and other contributions, would be sufficient to meet the operating cost including proper provision for depreciation of buildings and equipment?

Can hospitals anticipate a return in the near future of the time when the general public would generously give to hospitals to make up operating deficits?

It is the consensus of opinion of many persons that it will be many years before the return of the days when operating deficits will be made up by interested persons. If you, as a hospital administrator or trustee, share this opinion, is it not then incumbent upon the hospitals to develop a policy for revision of their rate structures so that income from patients will not only provide the operating expense, but an amount sufficient to provide a cash reserve for depreciation of buildings and equipment?

Many hospital administrators consistently take the position that the operation of a hospital can not be compared to that of private enterprise. While this may be a correct assumption up to a certain point, there is no question but what a considerable portion of hospital business can be conducted in the same manner as that of a private enterprise.

The development of periodic payment plans operated on a nonprofit basis, as well as the private insurance company plans, are without question providing a great many persons with a means by which they can protect themselves for hospital expense. The cash income from many of these patients exceeds that which has been the case in the past, as many subscribers were only part-pay patients. It is conceded that as these plans progress a greater percentage of the population will take advantage of such plans for their protection, and should result in fewer patients who can pay nothing or only a portion of the expense involved. However, regardless of how many patients you may serve who have hospitalization coverage, if the income from these patients is less than your expense, you will operate at a deficit. If a deficit is incurred under these conditions, there is less likelihood of the general public providing funds to meet such deficit, unless your records are so complete that you can show conclusively that your financial position is a result of community service.

Concerted Effort and Cooperation Important to the Voluntary Hospital System

For several years you have read many articles and heard many discussions concerning the future of the voluntary hospital. The voluntary hospital system, built up in the United States over a period of years, must be maintained. The voluntary system of hospitals as we know it, will be successful through concerted effort and cooperation. A greater degree of cooperation must be developed between a group of hospitals in a given community by common agreement that their common problems will be thoroughly discussed and the group will work together to develop rate structures which will provide sufficient income from pay patients, endowment income, income from government and private industry to meet the operating expense of these hospitals. As a hospital administrator or trustee, it therefore becomes an obligation as well as a duty to assist in the development of procedures and business practices that will assure continuation of the system of voluntary hospitals which will forever provide the citizens of this country with a free choice of hospitals.

Eighth Annual Institute for Hospital Administrators

University of Chicago, August 28 to September 11, 1940

A widespread interest in the Eighth Annual Chicago Institute for Hospital Administrators, which will be conducted by the American Hospital Association on the campus of The University of Chicago, August 28 to September 11, is indicated by the large number of requests for application blanks.

Each year an effort is made to confine the enrollment to 100 registrants. Applications are accepted in the order in which they are received. Those who contemplate attending the 1940 Institute should make their applications at the earliest possible date.

For application blanks and information regarding the Chicago Institute for Hospital Administrators write to *American Hospital Association, 18 East Division Street, Chicago, Illinois.*

Progress in Prevention of Anesthetic Explosions

WARREN P. MORRILL, M.D.

ANESTHESIA and asepsis are the twins which have made possible the development of modern surgery. Although they are barely a century old, it is difficult for us to picture the conditions which existed in the era of main strength surgery and "laudable pus."

Undoubtedly explosions have occurred for as long as inhalent anesthetics have been in use, since volatility is the inherent physical characteristic which makes their use possible and both leakage and unused anesthetic gas in the air exhaled tend to form an explosive mixture in air. However, for each anesthetic there is a definite range of concentrations in which the anesthetic must be given in order to produce anesthesia, and a definite range of mixtures with oxygen within which it is inflammable. It so happens that in the case of ethylene and cyclopropane, at least, these ranges are approximately the same.

Requirements for the Production of Combustion

There are three distinct requirements for the production of any combustion: a combustible substance, a supporter of combustion, oxygen, and a source of ignition. An explosion is simply a matter of rate of combustion or confinement of the combustion for a long enough period to permit the development of explosive pressure.

In the old days of open ether we had to deal with a mixture of air and ether vapor. But air contains only 20 per cent of oxygen and this small amount of oxygen, while adequate for the patient, did not produce as flammable a mixture as does the more modern ether and oxygen, or ether-nitrous oxide-oxygen, since the oxygen is present in much larger proportion in nitrous oxide than in air and in a form which is an active supporter of combustion.

When we were using open ether we usually banned any free flame in the operating room but permitted the use of the cautery as high up as the breast, provided there was a muslin barrier between the patient's face and the cautery area.

Presented at the meeting of Illinois, Indiana and Michigan State Associations of Nurse Anesthetists.

The Author

● **Dr. Warren P. Morrill is a member of the Headquarters Staff of the American Hospital Association, Chicago, Illinois.**

Open ether explosions from static electricity, or even from electrical apparatus such as motors or hand lights, were not usually considered. And while we may have had an occasional explosion, they were so rare that they never constituted a problem. It is probable that this arose from the fact that the ether vapor being 2½ times as heavy as air tended to sink toward the floor very rapidly, thereby preventing the accumulation of explosive concentrations in the immediate vicinity of the patient.

When ethylene appeared on the scene we began to have more explosions. Ethylene is very slightly lighter than air and, therefore, when mixed with air tends to respond to the laws of diffusion rather than the law of gravity—it floats. The concentration in the air thus becomes simply a result of the actual amount of the gas set free in the air either from the mask or from the patient's exhalation. Also, it is given mixed with oxygen in concentrations within the limits of flammability. Since the exhalation contains less of the anesthetic gas and much less oxygen than the inhalation, and a much larger proportion of the non-combustible carbon dioxide, it is probable that escapes of unused gases from the mask provide the major source of flammable concentrations.

Quite similar considerations apply to cyclopropane, though one characteristic—its weight is 1.45 times the weight of air—appears to conflict with the above considerations. If this theory were entirely valid cyclopropane should be less explosive than ethylene, but experience indicates that it is more so. This may be explained by some as yet undetermined characteristic of cyclopropane. In any case, it serves to illustrate the fact that we do not yet know all we need to know about the chemical and physical characteristics of these gases. This fact has led to the under-

taking of a research at the Massachusetts Institute of Technology in the hope that the key to the situation may be found and that means may be found to reduce or eliminate the hazards of these valuable agents.

Meantime, we are confronted with two facts. The first is that ethylene and cyclopropane, when used as anesthetics, do produce an explosive mixture. Incidentally, the same is true of ether-nitrous oxide-oxygen anesthesia. The other is that all three of these anesthetics have such outstanding advantages over the less explosive agents that they cannot be deserted. It is true that some hospitals have discontinued the use of cyclopropane, but many continue its use in the belief that its advantages save more lives than its explosiveness will sacrifice.

Until the chemists and physicists can tell us more about the prevention of the accumulation of explosive concentrations there is probably little we can do to prevent it. Anesthetists are, however, agreed that the use of the absorption method decreases the hazard to the extent that the unused exhaled anesthetic gas is returned to the machine and rebreathed, thus reducing the amount of gas set free in the room. Nevertheless, it should be noted that this method does not decrease the concentrations at the mask, and there is much evidence from such explosions as have occurred that it is the mask area and not room air as a whole which is the danger point. In fact, Professor Horton believes the danger area does not extend more than one foot from the point of leak, that is, the mask or some leak in the machine. While some investigators are not yet ready to accept this dictum, the fact is that of such explosions as have occurred, none has been proved to have originated at a greater distance.

Sources of Ignition

The production of combustion requires a third element—a source of ignition. Since it is quite evident that in using these anesthetics it is not possible to prevent the development of explosive concentrations, at least in the near neighborhood of the mask or of the machine, our efforts at the prevention of explosions will be more effective if directed at the control or elimination of sources of ignition.

In a study of 78 explosions in which the source of ignition could be determined, 6 were due to open flame and 16 were due to cautery. Certainly in the light of present knowledge these would be utterly inexcusable. Five were due to motors, location not stated. But those familiar with operating room procedure can readily understand that a pump motor is likely to be close to the gas machine, and any leak in the machine connections could easily provide sufficient of the inflammable gas to result in an explosion.

There are motors that, as delivered, can be called fairly spark proof, but in the small portable motor it is easily understandable how wear and tear might result in loosened connections, frayed or cracked insulation, or other defects which might render a once safe motor grossly unsafe. The remedy for this is self-evident—a spark proof motor in the first place, and rigid frequent inspection to see that it remains so.

Nine of the explosions were due to portable light appliances such as head lights, bronchoscopes, etc. While these appliances are probably relatively free from hazard when new and in good repair, it must be remembered that the production of light implies the production of heat, and that even when in the best of repair the bulbs themselves may in some cases become hot enough to ignite the gases. Since their use is in the dangerous zone it is certain that their use is not justifiable if it can be avoided, and that when used it must be only after careful inspection to determine if they have developed any ignition hazard.

Much of the same considerations apply to the use of the x-ray. The manufacturers of the modern self-contained shock proof x-ray machines feel that they carry no ignition hazards, but it is certain that loose connections, frayed or otherwise defective insulation may develop. They do have the advantage that they are not often placed in such close proximity to the danger zone.

Five of the explosions were given as due to oil. If oil is used on the leather washers or connections to an oxygen tank the friction of the gas passing the connection at high speed may generate sufficient heat to ignite the oil provided there is present a sufficient supply of oxygen to make combustion possible. The lesson is never to use any oil on or about any of the gas connections.

The reports from which these figures were taken included many dating several years back. It is not believed that reports of recent explosions would show such a large proportion of explosions from these causes, as these sources of ignition are now so well and so generally understood as to be explainable only by gross ignorance or grosser carelessness.

Static Electricity

But it is static electricity which, as we know now, always was the greatest single offender and with the present day elimination of almost all of

the above causes, it is probably responsible for far more explosions than all other causes put together.

The elusiveness of static electricity has cast an air of mystery about it. But its elimination requires at least a rule of thumb understanding of its origin and characteristics. Stripped of scientific niceties and technical verbiage, static electricity is a type of electricity which develops from friction and accumulates on physical objects even as small as a dust particle. When two static bearing objects come into contact, the one bearing the higher potential discharges to the one bearing a lower potential until the charges of the two are equal. The earth may be regarded as having a zero potential, and hence when brought into contact with the earth, either directly or through an adequate conductor, the entire charge is discharged to the earth. Thus a radiator or any metallic part of the building being connected directly or indirectly to the earth may be expected to have a zero potential and thus capable of receiving but not of giving a discharge. Although air is a non-conductor, static electricity may accumulate on an object to a sufficiently high potential to enable it to overcome the resistance of the air and jump the gap between it and any object of sufficiently lower potential which is near enough. This "jump" generates a high enough degree of heat to be seen as a spark and capable of igniting any combustible substance in its path.

The extent to which objects may accumulate static varies with their conductivity. Thus silk, rubber, glass and woolen are most prone of ordinary materials to accumulate static while textiles of vegetable origin, wood, etc., are less prone to do so. Also since water is a good conductor, the more moist an object is, the less static it accumulates. This explains the experience we all have had of walking across a rug in winter time—a time of low humidity—and accumulating enough static to produce a sharp spark when we approached any metallic object or even another person who had not been in motion and had, therefore, a lower electrical potential. This phenomenon does not occur so readily in the relatively humid conditions of summer because the humidity provides a relatively conductive medium and allows the static to leak away to the earth as rapidly as it is generated.

Some appreciation of this principle may be gained from such observations as: a gust of air blowing through a door developed a static charge of 50 volts; a man wearing dry leather soled shoes walking on a dry floor developed a potential of 500 volts in four steps; an anesthetist sitting on a rubber cushioned stool developed a potential of 5,000 volts.

These observations indicate that we cannot hope to entirely prevent the generation of static electricity, though we may minimize it. But we can prevent its accumulation by providing channels through which it can trickle away as fast as generated. The brook cannot form a pool unless its outlet is dammed at some point.

The early efforts to provide for the elimination of static were to ground the gas apparatus by a metallic connection to a radiator. But this grounded the machine only. The next step was to use a large floor shield of metal and grounding through that. This method provided for every person or object on the shield. This method was soon modified by the introduction of metal grids in the floor, the grids in turn being grounded through some part of the structure. This method was adequate to prevent the accumulation of static on any object which was in electrical contact with any portion of the grid. However, it was soon realized that this method did not ensure that all objects able to generate or accumulate static would be in such contact. It was still possible for a potential to accumulate on a dry nonconductive surface a very short distance from a grid or any other metallic object. The logical answer to this was the maintenance of a sufficient humidity of the air to ensure that every surface of every object in the room should accumulate sufficient moisture to afford a channel for the surface conduction of such static as might be generated. The dry cleaning industry in its use of flammable solvents had been faced with a comparable problem and had found that the maintenance of a relative humidity of 60 per cent had been adequate. This percentage was therefore assumed to be sufficient to give adequate protection in the operating room. Lately some doubt has been expressed as to the sufficiency of a 60 per cent humidity, the doubters claiming that it should be at least 65 per cent. More recently one authority has raised the question whether it is relative humidity or absolute humidity which determines conductivity and experiments to answer this question are already projected. And, in fact, at least one explosion has been reported as having been due to static in the presence of a relative humidity in excess of 60 per cent. But the maintenance of humidity may not alone be sufficient. For instance, rubber shod equipment or personnel may be sufficiently insulated to prevent the static they generate from access to a humid surface and thus may build up a relatively high potential. To avoid this possibility it is necessary to avoid the use of non-conductive material for shoes of personnel, for tips for tables, stools, etc., or for tires for wheeled equipment. In this connection it may be said that the rubber

manufacturers have succeeded in producing a rubber which is sufficiently conductive to serve the purpose. Work is being done to the same end with an artificial rubber, neoprene, and at least one caster manufacturer is working to the same objective.

Wool is one of the most potent accumulators of static. At least two explosions have been attributed to static produced by the friction of a woolen garment against the drapes of the operating table, and the most recently reported explosion has been attributed to static produced during the adjustment of a woolen blanket about the patient.

The Intercoupler

The intensity of a static discharge is proportional to the difference in potential between the two objects concerned. Thus an object having a charge of 500 volts brought in contact with an object having a charge of 200 volts would have a discharge represented by the difference in the two charges, or 300 volts. Based on this fact there has recently been devised a so-called intercoupler by the use of which a metallic circuit is established and maintained between the patient, the anesthetist, the operating table, and the anesthetic apparatus. This can also be arranged for a fifth connection—to the floor—if desired. The use of this device will ensure that the potential of all persons and objects so connected will be equalized and no discharge will be possible. The surgeon and his operative assistants being in contact with the moist tissues of the patient automatically become a part of this hookup. A defect is that the instrument nurse or other person or object which may come into contact with any of the above may have a different potential and thus cause a discharge. In practice this may not be a serious hazard provided such contact and consequent discharge do not take place within the zone of flammable concentration, that is in close proximity to the mask or a leak in the apparatus.

One way to provide for the discharge of static from wheeled apparatus is the use of a dangle chain providing for continuous discharge to the floor. Another device has been the placing of a grounded brass plate at the entrance so wide that every person entering the room must step on it. The weakness of this is that if the person is wearing shoes with rubber or other non-conductive soles, the discharge may not take place.

Electrical Equipment and Fixtures

There is still a third group of possible hazards to be discussed. This group consists of the operating room light, wall switches and outlets, emergency light, etc. These hazards are as yet entirely theoretical as none of them has yet been reported as responsible for an explosion. Of these, the most hazardous is probably the wall outlet and plug, as a spark may occur at the time that a connection is made or broken and the outlet, at least, is usually located near the floor, that is, at the location in which there is most likely to be an accumulation of gases in sufficient concentration to be flammable. It has been shown in other connections that a heavy gas, carbon disulphide for instance, may accumulate and "channel" along the floor for as much as fifty feet in sufficient concentration to be explosive. The ordinary switch likewise may produce a spark but is usually placed four to five feet from the floor where there is less likelihood of an accumulation of gases. Another phase of this problem is that the placing of the anesthetic apparatus in the room may be such as to bring it in close proximity to the outlets or switches and in case of any leak in the apparatus, they would then constitute a definite hazard. The same considerations apply to the self-contained storage battery type of emergency or spot light. As far as the fixed operating room light is concerned it is so remote from the point of concentration of gases that it is in the least hazardous location in the operating room. There can be no serious objection to the use of an explosion proof operating room light if such a light can be designed without loss of other and more valuable characteristics such as light value and adjustability.

It is not considered advisable to place too much emphasis on this group of hazards in view of the fact that too much emphasis on these relatively unimportant items may distract the attention from the much more common and proven hazards.

Little has been said about anesthetic apparatus. The manufacturers have been alert to meet every new safety demand. The principal one of these is the thorough internal grounding of the machine. Likewise, anesthetists are taught to thoroughly wet the inside of the tube and bags as a further precaution. Now there is an effort under way to design a reflux valve to be placed in the tube to prevent an explosion which has originated at the mask from communicating back through the tube to the rebreathing bag. Since this is essentially locking the stable after the horse is stolen, explosion experts have not yet shown any great enthusiasm for it. Perhaps the greatest advance in making the machines safe has been incidental to the development of entirely different advantages. The use of the so-called absorption method so decreases the amount of the flammable gas that is set free in the room that it is difficult to conceive of a sufficient accumulation of the gas to be explosive, to be present at any point except at the

mask or at some leak in the apparatus or its appurtenances.

Summary

1 The flammable anesthetics present so many advantages from the patient's standpoint that their abandonment is unthinkable.

2 The concentration required for anesthesia coincides so closely with that required for flammability that the explosion hazard is ever present, at least in a comparatively small zone surrounding the point of emission, either the mask or a leak in the apparatus. The extent of this zone is as yet undetermined, but may be assumed to extend less than two feet from the point of emission.

3 The elimination of sources of ignition is the most promising method of decreasing the explosion hazard.

4 The elimination of sparks from defective equipment is partly a matter of the proper selection of such apparatus, but to an even greater extent a matter of their proper maintenance.

5 The use of cautery or any sparking apparatus in the presence of flammable gases is very dangerous.

6 Static electricity is responsible for more ignition hazards than all other ignition sources combined.

7 Ordinary rubber and wool present so many static hazards that they must be rigidly excluded from the operating room.

8 While the generation of static cannot be entirely prevented, its accumulation can be prevented by the provision of adequate channels for its dissipation.

9 Metallic grounding is inadequate and must be supplemented by the maintenance of a humidity of at least 60 per cent at all times when any of these flammable anesthetics are in use.

Tax Laws Encourage Gifts to Charitable Organizations

Tax experts today have only one effective answer to the taxpayer, particularly the man in the higher brackets, who is seeking partial respite in the burden of his tax payments. "Give to a charitable institution," is the message they bring, for indeed, government—Federal, state, and local—is a silent partner of every taxpayer who makes a contribution to a hospital or any other charitable organization. By the very terms of the various tax laws, they encourage gifts and bequests to charitable, educational, and religious organizations.

Under the Federal income tax statute, for instance, an individual may deduct from his gross income, in determining his taxable net income, all contributions or gifts made within the taxable year, to or for the use of a charitable organization, up to fifteen per cent of the taxpayer's net income. Since 1936 similar deductions, up to five per cent, have been allowed to corporations.

While every taxpayer, particularly in the high tax brackets, is painfully aware of the burden of such taxes, the majority people do not appreciate the important part played by these taxes in the case of charitable gifts.

Henry H. Stern,
Jewish Hospital Bulletin, St. Louis, Missouri

Eighth American Scientific Congress

The Department of State has recently released a tentative program of the Eighth American Scientific Congress, which will be held in Washington, D. C., May 10-18. This Congress, which will bring together distinguished scientists and scholars from all the Americas, will assist in the celebration of the Fiftieth Anniversary of the Pan-American Union.

The Congress will be formally opened by President Roosevelt on Friday, May 10. The ceremony will take place in the Pan-American Union. The organization of the various sections will be completed on the morning of May 11.

Following are the established sections of the Congress:

I—Anthropological Sciences
II—Biological Sciences
III—Geological Sciences
IV—Agriculture and Conservation
V—Public Health and Medicine
VI—Physical and Chemical Sciences
VII—Statistics
VIII—History and Geography
IX—International Law, Public Law and Jurisprudence
X—Economics and Sociology
XI—Education

Opportunities in Public Health Program for Community Hospital Participation

W. F. WALKER, D.P.H.

WHENEVER I think of the relationships between the hospitals of a community and its health department, I am reminded of a remark made by George Vincent, one time president of the Rockefeller Foundation, concerning the relations of the training of public health officers and physicians. Dr. Vincent had discussed how in an endeavor to tie public health training more closely to medical education, the Foundation had built a school of public health at one of the great universities directly across the street from the medical school in hopes that the faculties would find more and more things in common and gradually grow together in the interest of a better service for the public. In recounting this experience, Dr. Vincent concluded: "there these two great institutions of learning have stood for years, shoulder to shoulder, yes—cold shoulder to cold shoulder."

It seems to me we have practically identical problems in developing sound working relationships between public health agencies and hospitals. I always wince just a bit when I make this distinction because the mere fact that we do not ordinarily include hospitals among the public health agencies of a community serves to set them apart and widen the gap where there is no sharp line of demarcation between the responsibility of a public health department and of a community hospital. Both have responsibilities for the care of the sick. Frequently these responsibilities affect the same individual. Both have opportunities for community education in matters of health though the health department may, through the nursing service, reach the homes of the community a little more extensively but possibly not so intimately. Both have responsibilities, though frequently unrecognized, for increasing the efficiency of their own service to the community in aiding private agencies, even private physicians, in rendering a better service.

With all these common interests, it is not infrequent that we see the hospital or hospitals and the health department putting on a typical "brother and sister act" so common in the ordinary American family. These two agencies, both of the same parents—the community—supported from the same pocketbook—the community's—having equal responsibilities for contributing to wholesome family life, all too often assume an attitude of indifference, jealousy, or open antagonism toward each other, missing entirely the possibilities of winning larger support, kudos, and the satisfaction of broader service through the development of mutual understanding and cooperative approach to their necessarily interrelated problems.

The Author

● **Dr. W. F. Walker is Director, Division of Health Studies of The Commonwealth Fund, New York City.**

Duplication of Equipment and Personnel

While this picture of relationship between these institutions of potentially great public service is not universal, it happens so frequently that we are all familiar with it.

Let us then consider some of the opportunities for cooperation between these agencies which will be in the direction of better public service and lead to closer relations. Several years ago, a joint committee of the American Hospital Association and the American Public Health Association explored the field to discover the services in which hospitals and health departments might operate jointly. It was found at that time that diagnostic aids were frequently carried as a joint function. The bacteriological and chemical laboratory service for the community of considerable size can very well be done in a single laboratory with the opportunity of securing better trained personnel offering a higher type of service and frequently with the gratifying result of lower costs. The arguments often made against such a service are

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that administrative control cannot be fixed in either the hospital or the health department. The health officer thinks that the director of the laboratory should be immediately responsible to him and that the so-called public health diagnostic work should have priority, while the superintendent of the hospital or the chief of staff may feel that the laboratory work for the critically ill patient should have the right of way. Experience has shown that the problems can be solved if the individuals concerned adopt a community point of view and the laboratory is reasonably adequately staffed.

We not infrequently see the x-ray equipment which the hospital must have in order to function, duplicated in whole or in part in the health department. This duplication of equipment and personnel and space is all costly to the community without guaranteeing any commensurate improvement in character of service.

In the therapeutic fields for ambulant patients we all too commonly find duplication of equipment for artificial pneumothorax, for the diagnosis and treatment of syphilis, for dental care, unused a large part of the time, but considered an essential by each institution because they are unwilling to share their interest in a particular group of patients or public problem with another agency.

The first axiom then of better cooperation may be stated "avoid duplication of expensive equipment and personnel."

Continuity of Service

There are a number of services in which public health departments must cooperate with some hospital if effective work is to be done and success depends upon the continuity of service to the patient. An excellent example of this is service for maternity hygiene. It is now common practice for health departments to carry programs for maternity hygiene including an instructive nursing service in the antepartum and postpartum periods. Medical service is provided either by the private physicians, clinics in the health department, or by out-patient service in the hospital. Only in occasional instances does the health department concern itself with the delivery service. Delivery may be in the home by physician or midwife, or in the hospital. It is rare indeed that the hospital has knowledge of cases under health department supervision until they come in, in labor because of some complication, unless the case is carried by the out-patient department. The health department frequently knows the patient's plans for delivery and could easily inform the hospital of cases likely to come in either as normal or emergency cases.

So you will not think all of the opportunities for cooperation rest with the health department, may I point out that it would be equally easy for the hospital to advise the health department of the expected date of discharge of the mother and new baby so that the field contact made in the antepartum period could be renewed without delay to the benefit, I believe, of the patient and mutual advantage of both agencies. The criticism is often made that health departments express deep concern about the welfare of the mother during the antepartum period and the mother and baby in the postpartum period, but desert the mother at the most critical time. A little forethought and planning by these two community agencies would bridge this gap for many patients and give them increased confidence in both agencies. Such coordination of public health and community hospital service is daily being practiced in many communities, possibly the most extensive example is the experience of Alameda County, California.

Very similar situations exist in the care of the tuberculous, the diabetics, and frequently the crippled child, and it is my observation that in these fields the health department is more likely to establish contact with the hospital prior to admission of the case and to provide for continuity at this point than is the hospital to insure continuity of service at time of discharge by reporting the patient back for home care. True it is that hospital superintendents usually have enough problems within their walls to take all of their attention, but their support comes from the community and it is only through coordinated efforts of all agencies that the best community service results.

The lack of forethought which results in the breaks in continuity of service in the fields just discussed also results in wasted effort and inefficiency in other clinical fields. It is customary now for hospitals to recognize their responsibility to the ambulant patient by the organization and conduct of an out-patient service, usually broadly conceived as to scope of service. It is equally common for health officers to plan for medical advisory services in fields of special public health interest. It is the rare community indeed which will not have duplicate clinics set up for maternity hygiene, pediatrics, tuberculosis, syphilis, heart, and many other fields which will occur to you. Occasionally, a medical leader in a field such as tuberculosis, or pediatrics, or syphilis, or heart disease, will coordinate the clinical activities in his particular field and develop a community program which makes the best use of all the facilities available, distributing services with regard for the geographic distribution of the population, transportation facilities, etc. Under such leader-

ship, remarkable results are accomplished, public approval and support secured, and the service proportionately benefited.

Success in a single area, however, does not seem to stimulate health officers and hospital superintendents or even medical leaders to plan coordinated clinical services throughout and we see the Commissioner of Hospitals and the Commissioner of Health of one of our largest cities engaged in mortal combat in the public press over who will have control of the clinic services that belong to neither but are the sole property of the supporting public.

Though in some places harmonious working relations between the preventive and curative services in the community are brought about by making the health officer superintendent of the hospital, or vice versa, as was the case in Spartanburg, South Carolina, the experience in Sullivan County, Tennessee, proves that a health department, operating as an independent agency, can cooperate in the closest and most effective ways with community hospitals in two small cities.

Opportunities For Health Education

Possibly one of the greatest hazards which hospitals must overcome in developing a point of view for cooperation in the public health program grows out of their traditions. They are places for the acutely ill, to many lay people, and unfortunately also to many physicians. Out-patient services grew out of the old dispensary but one need not look far to find instances today of the prescription being the central feature of the service with only a modicum of diagnostic skill and practically no instruction or health education accompanying it. Yet the services set up for obstetrics, pediatrics, tuberculosis, syphilis, heart disease, diabetes, cancer, mental hygiene, to mention only a few, all hold great possibilities for health teaching for the benefit of the individual and the community which are rarely realized by hospital outpatient departments and practically never carried out as a joint project of the hospital and public health agency.

Communicable Diseases

In large communities, the incidence of the communicable diseases will usually be great enough to warrant special hospital facilities operated by the city. In smaller cities, however, this is not feasible because of the high cost. Here the community hospital has an excellent opportunity to contribute to the improvement of service by planning and making available a few beds which can be used for the care of the occasional case of an acute communicable disease that needs hospitalization.

Recent experience has shown that all of the safeguards of isolation can be carried out within the hospital through due consideration of medical asepsis. Community hospitals are frequently the discoverers of new and strange communicable and contagious diseases in the community. The health department has diagnostic skill and aids in this field which the hospital should use. The prompt reporting of cases and suspects by the hospital will be appreciated and will frequently enlist public aid in the handling of the case which the hospital will be unable to secure alone.

Raising the Level of Medical Practice

Hospitals and health departments exist in communities because the public has learned from experience that there are some services which the individual cannot provide for himself independently as well as he can through group action. In this way, both institutions have a common objective in seeking to provide in the community better medical service than would otherwise be available. Their responsibility, however, is not limited to a handmaiden type of service to physicians but includes helping the physician in private practice to keep abreast of the development of knowledge. The most frequent service in this field is the diagnostic service provided by laboratory facilities already discussed. Through special consultants, hospitals and health departments are finding it possible to improve the diagnostic service and to extend this specialized influence into therapeutics. We are all familiar with what has been done in this regard in tuberculosis, pneumonia, and cancer, and other fields.

More recently attention has been directed at postgraduate education through extension courses and hospitals and health departments are finding opportunities for joint action in bringing qualified men in various fields for staff meetings or other occasions, so that the busy local physicians may have the benefit of expert discussion of current problems. In a number of instances, the health officer, as a regular attendant at hospital staff meetings, has stimulated a preventive point of view among staff members by discussion of the public health aspects of specific cases.

Mutual Recognition of Problems

In the past, there has frequently been a good reason why hospitals have not sought the cooperation of the health departments. Unfortunately, many health officers had had little or no training for their particular jobs, were political appointees with scant interest in the long time welfare of the

community beyond their immediate term of office. This situation is rapidly changing, however, as more young men are electing public health work as a career and have special training beyond their basic medical or other preparation for the work. They will bring a community point of view to the discussion of mutual problems which the hospital superintendent will do well to utilize.

The American Hospital Association and the American Public Health Association have recognized the advantage of community planning in matters relating to the hospitals and the public health and have advocated the organization of hospital councils to stimulate such planning. Many communities, however, having but one or two hospitals will find this machinery too cumbersome for their needs. Equally satisfactory results can be obtained by less formal means through planned meetings of the health officer and hospital superintendents.

There must be mutual recognition of the problems and the program carried on by each group. The necessity of fund-raising from taxes or other sources must be appreciated and the limitations of resources in many communities recognized if the most equitable and efficient arrangement of budget and program is to result. We are considering two essential community services which should present a common front to the public in terms of the value of their contribution and need of their maintenance. Arguments as to the relative importance of either one over the other serve only to breed distrust. Increased public, financial, and moral support lies only in the direction of a closer welding together for more economical and effective service.

The Business Office Helps

J. L. Lathan, Cashier, and R. D. Miller, M.D., administrator intern of Passavant Hospital, Chicago, have cooperated in preparing a booklet for members of the medical staff of the hospital outlining a simple system for their accounts.

The physician just starting his practice usually begins his bookkeeping system by pocketing his cash and forgetting to fill out his check stubs.

The business office of Passavant Memorial Hospital has been asked from time to time for help in this direction, "How shall I set up my office books?"

To give the best help in this, a small booklet was prepared outlining a suitable, and at the same time, simple plan. Any physician wanting this information is given one of these booklets.

No previous knowledge of bookkeeping is necessary to fully understand this outline. It is set up on a cash rather than an accrual basis. The number of books has been kept to a minimum and once the start has been made, the physician can change the system to fit his separate needs.

Samples of the sheets are included and are of the variety handled by the majority of stationers.

The first section in the booklet is given over to a short discussion on general principles of balancing receipts and disbursements, making bank deposits, and methods of checking bank statements. The second section outlines the actual bookkeeping process with a description of the books. The last section discusses depreciation of automobile and office equipment, bad accounts, charity and their relation to income tax allowances.

Day Book—Cash Receipts—Disbursement Record

The starting point in the system is the day book; this, of course, is the book of original entry. In this book are entered the names of persons given professional services and other sources of income; opposite the name, a space is provided for an explanation of service; then two columns for cash for professional services and miscellaneous cash. The next column is for charges made but no cash collected.

The second book suggested is for cash receipts and disbursements with subdivisions for bank deposits, checks withdrawn; cash is divided into receipts and disbursements; income is divided into services and miscellaneous.

Separate books are outlined for property and equipment purposes.

This is a small service but will be appreciated by the physician and will do considerable toward hospital-physician relationship.

Interdependence of Hospitals and Service Plans

FRED G. CARTER, M.D.

ALTHOUGH I have been assigned a definite subject I hope that I may be forgiven if I depart somewhat from it in the beginning. A number of things occur to me that I would like to say to this particular group while I have the opportunity.

First of all I am impressed by the number of new faces I see, faces that I do not see regularly in the many hospital meetings which I attend routinely. Here then is a new phase of hospital service presided over by men and women who are relatively new to the beaten trails in the majority of instances. For every one of the two hundred fifty or more here present I was told there are at least twenty back home, carrying on the work in which all of you are engaged, a total of approximately five thousand persons. And your particular work was practically unheard of ten years ago!

Next I am impressed with the fact that a very definite group consciousness has developed among you. Evidence of this is found in the very fact that you are meeting here to discuss problems peculiar to your particular activities. You have evolved a lingo or language all your own. I hear terms glibly spoken such as selection, utilization, experience, exposure, reciprocal enrollment, reciprocal benefits, preferential rates and cancellations. As I left the meeting this morning I entered a room in which there was a table piled high with pamphlets, reprints, bulletins and booklets indicating the gradual development of a literature in your special field. Around about me I hear expressed a desire for a national forum of some kind through which you may give voice to your opinions and convictions concerning hospital service work. These are earmarks of an advancing group consciousness.

To me all of this is most impressive not only because of immediate implications but also because it illustrates a way out of our national economic dilemma. When we cannot find entirely new outlets for the energies and abilities of our citizens we must explore old activities for neglected bits which when pieced together will reveal new occupations. In this group as previously stated, we have represented five thousand people who are doing a $40,000,000 business annually—a business that was almost unknown ten years ago. I am deeply moved by and extremely proud of your accomplishments and I am particularly happy to think that the hospital field may point to your work as its stabilizing contribution to the uncertainties of depression and economic upheaval.

The Author

● **Dr. Fred G. Carter is President of the American Hospital Association and Superintendent of St. Luke's Hospital, Cleveland, Ohio.**

The Growth of Hospital Service Plans

For a movement that was conceived in failure —the failure of hospitals to balance their budgets—nurtured in depression and brought to fruition in an embarrassed national administration, group hospitalization today represents a pretty lusty infant. Perhaps the terminology is no longer applicable since we think of an infant as a baby and a baby as an alimentary canal with a loud voice at one end and total irresponsibility at the other. Maybe we should prefer to think of group hospitalization as being well advanced into the period of childhood for the child up to the age of ten is really the original thinker among us. He learns by doing and he profits by his mistakes as well as his successes. To him nothing is impossible, he takes nothing for granted, a "don't" is a "dare." Unfortunately from the standpoint of his mental development but fortunately for those who must live and associate with him, at the age of about ten he begins to give way to the conformity demanded by custom and tradition which only genius can escape.

Strangely enough group hospitalization has just turned ten and everywhere round about it the forces of conformity are already at work.

Presented at the Mid-Winter Conference of Hospital Service Plans, Pittsburgh, Pennsylvania.

Gradually it is being forced into the mould which has given form and character to its elders. Childhood is almost a thing of the past. Already it is growing like a weed, its voice is changing, it is beginning to notice and imitate and compete with others of like interests. Soon it will enter the mad struggle for its very existence and where heretofore it has been tolerated because of its youthfulness it will be shown no quarter, extended no sympathy, outside its own family.

Two Purposes of Group Hospitalization Plans

Group hospitalization came into being to serve two distinct purposes, the first of which was to make hospitalization available to the public at prices which it could afford to pay, and the second of which had to do with solving some of the financial problems of hospitals. Which came first in the thinking of the pioneers in the field is of no particular concern, but there are certain aspects of the movement which should be of immediate and lasting importance to both hospitals and plans. These divide themselves into two groups, the one having to do with the dependence of the hospitals on the plans and the other with the dependence of the plans on the hospitals.

Let us consider first the dependence of the hospitals on the plans together with some of the implications thereof.

In communities where active service plans are operating, the hospitals are becoming more and more dependent upon them for payment for services rendered. In Cleveland, for example, more than one-fifth of the income from patients of member hospitals comes from this source and the proportion is increasing. Other communities are having similar experiences, no doubt. Offhand this result seems highly desirable but such a situation is not without its dangers. As the movement grows and the proportion of hospital income from this source increases, the per capita income of the hospitals tends to become fixed at a level which in many instances is somewhat below per capita costs. In the meantime the per capita costs may increase and the disparity between the two may prove ruinous to the financial structure of hospitals. This situation becomes doubly serious when we stop to realize that many of those who formerly constituted our paying clientele, upon whom we depended for certain profits to offset losses on free and part pay work, now come to us as subscribers to hospital service plans. In the face of such facts it becomes obvious that unless the plans make every effort to keep their per diem rates to hospitals at levels approximately equal to per capita costs the hospitals in order to avoid embarrassment may find it necessary to devise services to sell down to a price instead of up to a standard. This is not what we Americans want in the way of hospital service.

Direct Payments for Service Rendered

The hospitals are indebted to the plans for establishing and maintaining the principle of direct payments to hospitals. While it is true that subscribers to cash indemnity plans may authorize or assign payments to hospitals, the fact remains that some of them may pocket their benefits leaving the hospital with accounts receivable which eventually may have to be charged to bad debts.

Probably the greatest publicity agent for hospitals that has ever been devised is the group hospitalization plan. With representatives of these plans going into factories, business establishments, schools, and other places where humans congregate in great numbers, telling the story of hospitals and answering questions pertaining to them, the result cannot be anything but beneficial from a publicity standpoint. The newspaper and radio publicity of the plans has served to bring hospitals before the reading and listening public in a helpful, secondary way, without risking the evil effects of ill-advised publicity efforts on the part of the hospitals themselves. In recent months we have heard much about a joint publicity program sponsored by hospitals and service plans, but I am not too certain that such a venture would be desirable from all standpoints. A single unfortunate release might do more damage to the hospital or hospitals participating in it than a dozen good ones could undo. From a hospital standpoint the best kind of public opinion is that which crystallizes from word-of-mouth persuasion, and this is what we are getting from service plan representatives.

Hospitals Dependent on Plans for Equitable Financial Arrangement

Hospitals are dependent upon the plans to set the pace for the insurance companies in the matter of benefits to both hospitals and subscribers. Before talking to this point I would call attention to the fact that of late the question has arisen as to whether or not hospitals should accept payments direct from the insurance companies which sponsor group hospitalization plans. I must admit that I have yet to find very many hospital administrators who will refuse money from any source whether it be in the shape of the "back rub" of prohibition days or the proceeds of "bingo" games. With certain exceptions which are deplored as much by the majority of good insurance companies as they are by any of us, the insurance

companies are fine upstanding members of society. As long as their payments are only to be applied to regular hospital bills with no service contract involvement, there can be no threat to the welfare of either hospitals or plans in this arrangement for direct payments. Given a free rein, however, with no competition from the nonprofit plans as pace setters, it is conceivable that the insurance companies might exercise their human prerogative as they have in past relations with hospitals to take all they can get and give as little in return as possible. Hospitals therefore are dependent upon their own plans for equitable financial arrangements in their relationships with those who make the underwriting of hospitalization risks their business.

The Free Choice of Hospital and Physician

Hospitals are dependent upon the service plans to preserve the free choice clause of hospital insurance. It is conceivable if nonprofit service plans should suddenly drop out of the picture that a mad scramble for low rates for hospital care might ensue with preference being shown to low-cost institutions without much regard for service standards. The choice of physician might also be dictated to the detriment of the patient as well as the high grade hospital. As long as patients have a free choice of hospital and physician they will tend to gravitate to the better institutions. The latter will be encouraged to maintain their standards of service and the poorer institutions will try to improve theirs.

Time of Hospitalization of Patient Decreasing

Since the advent of hospital service plans the average stay of the patient in the hospital has been decreasing which may mean that people are learning to use hospitals, not as places of last resort but as proper places to go in times of illness or injury. They seem to be realizing that by going to the hospital early the period of disability is shortened. Hospitals are grateful to the service plans because they have encouraged greater utilization of hospital service. Under such conditions the results which hospitals and the medical profession strive for are going to improve each year. As group hospitalization becomes more and more widespread it will be interesting to watch the experience of the large insurance companies in the life and disability fields. Their records should reflect definite improvement as a result of hospital service being made easily available. If they do not, there is something wrong with hospitals or the medical profession or both.

Promoting Team Work

Hospital service plans have done much to promote team work among the hospitals. By uniting to promote such plans they have learned that much is to be gained through cooperation and this knowledge is bound to find applications in many other phases of hospital endeavor.

The relationship between hospitals and service plans is by no means one-sided with the benefits accruing only to hospitals. The service plans are dependent upon the hospitals for a number of highly important contributions to their welfare, so now let us turn to this second phase of the discussion.

It seems fair to state that the hospitals by guaranteeing to subscribers the benefits outlined in their contracts carry the lion's share of any risk that may be involved in underwriting the hazards of hospitalized illness. Whether it be an improper selection of risks, high incidence of illness among subscribers as in an epidemic, or just plain mismanagement, hospitals in the majority of plans are liable for the fulfillment of the contract with the subscriber. Certainly plan executives could not ask for a more convincing argument than this on the question of the loyalty of the hospitals to their plans.

Selling Hospital Service

For the most part the hospital service plans are the only organizations outside of the hospitals themselves that can sell hospital service. The vast majority of all other schemes are on a cash indemnity basis. This arrangement permits the service plans to guarantee that every service listed in the contract will be provided whereas the cash indemnity plans can guarantee only certain amounts of cash to be applied on hospital bills. This close identification of the plans with the hospitals has great sales value. Without it the plans revert to the role of insurance companies and their identities are lost.

Hospitals are community enterprises and in almost all cases they enjoy the confidence, respect, and support of their communities. Through their sponsorship of group hospitalization plans they have shared with them the esteem in which they are held and thereby have helped to build good will for the plans in the minds of the public.

From this partial recital of examples of the interdependence of hospitals and plans it becomes obvious that the two activities are necessary accompaniments of each other, each vital to the existence of the other and both blended into a single front for the improvement of hospital service. Nothing must be allowed to alter this relationship.

If I may be permitted to deviate from the subject I would like to speculate for a few minutes

on the full significance of the group hospitalization movement and its relationships to the hospital movement. Who knows? Perhaps this new development may contain the germ of an idea which may revolutionize the management of the care of the sick. We recall that not so long ago business and industry in this country were made up of many very small independent units. Within the lives of the majority of us these units have given way to large corporations giving nation-wide management to particular fields. The directors of these corporations are not narrow in their thinking. They keep in mind nation-wide application of their services and exercise broad vision in the development of their methods. If they were to think only of the single process of manufacturing, dissociating it entirely from the problems of sales, distribution, supply, and finance we would still be paying $20,000 each for automobiles of inferior quality.

National Unity Among Hospitals

Individual hospitals have been and still are arbiters of their own destinies but with the newly awakened social conscience, we may be at the cross roads. Possibly the time has arrived for something entirely different. In recent years we have witnessed the growth of the hospital council idea with the hospitals of a particular community or area joining together to work out problems of interrelationship. Then we have the development of group hospitalization, first by the single hospital for a single group of school teachers, then the city-wide plan with the inclusion of the representatives of occupations of all kinds. Next came the interurban and intercounty plans and finally the state-wide plan. Now in many parts of the country we have local sponsorship but nation-wide and even international coverage of the subscribers. Congressmen are interesting themselves in the hospital needs of the citizenry of all classes.

The President, himself, has the hospital problem in mind. Uniform accounting in hospitals is rapidly finding favor. Some of our churches and fraternal organizations sponsor hospitals throughout the nation. Some of the great philanthropic foundations are experimenting with problems in hospital location and management. Our great state and national forums provide opportunities for discussing hospital questions. Service plans in the hospital field certainly offer, among other things, a striking comparison with the far-flung finance corporation of industry. Do all of these things point in the direction of a national unity among hospitals parallelling the national unity found in business and industry?

I am not advocating anything. I am simply looking at the symtomatology and wondering, wondering as to the future of hospitals, wondering whether the group hospitalization movement may prove to be the fuse that will touch off a process leading to the amalgamation of our hospitals into a great, nation-wide cooperative system of caring for the sick and injured on a nonprofit basis, in the widest application of the term.

Dr. S. S. Goldwater, in submitting the budget of $32,750,000 for 1940 for the Department of Hospitals of Greater New York, of which he is the commissioner, says:

"To understand the meaning of the budget of the Department of Hospitals, it is necessary to bear in mind the place which the Department occupies in the life of the people of the city, the extent of its responsibilities under the charter, the demands and expectations of the citizenry and of professional and civic agencies, and the Department's unremitting struggle to supply deficiencies in its equipment and organization and to maintain the municipal hospital service on a plane of equality with that of approved voluntary hospitals. Since these matters are periodically presented in the Department's annual reports, it is unnecessary to discuss them at any length here.

"Nearly half of our people rely on the city's hospital system for institutional care in critical emergencies. The capacity of the Department's institutions is approximately 20,000 beds; actual occupancy always runs close to and frequently exceeds by far 100 per cent of normal capacity. Moreover, municipal hospitals, in contradistinction to voluntary hospitals, are required to operate under an eight-hour law.

"During the fiscal year here under consideration, the Department will be required to provide approximately 7,000,000 days of hospital care, and in addition, some 3,000,000 treatments will be called for in the out-patient departments. It is against this background that the budget of the Department must be studied."

The voluntary hospitals of Massachusetts have a valuation in land, buildings, and endowment funds in excess of $135,000,000. The free care given by the voluntary hospitals in Massachusetts, at cost valuation, amounts to the sum of $4,750,000 each year. They afford gainful employment for more than 12,000 men and women.

Infections in Hospitals – What the Administrator Should Do Toward Their Control

J. J. GOLUB, M.D.

HOSPITAL service must be of high order, of course, but it also must assure the patient's safety. The achievement of safety is a challenge to the hospital administrator. It becomes one of his most alluring tasks.

Even the fortunate administrator of a well-planned, soundly constructed and intelligently equipped hospital soon realizes that such fortune of itself is not sufficient to prevent the occurrence of infection in surgery and childbirth, nor is it sufficient to avoid the spread of infection from patient to patient, patient to personnel, and personnel to patient. He would still need: (1) vigilant supervision of technics and procedures; (2) methodical ways of detecting faulty equipment; (3) appreciation of the germicidal effect of sun rays; and (4) sustained maintenance of efficient ventilation.

Air-Borne and Droplet-Borne Infections

Before discussing the above four points, brief mention might be made of air-borne and droplet-borne infections. We all recall the era when attempts were made to kill bacteria and spores with gaseous disinfectants. Fumigation of rooms vacated by patients suffering from infectious diseases was popular for a long time. The germicidal effect was supposed to have been on the air, the room surfaces and contents. The ineffectiveness of fumigation has since been established. Air dissemination of bacteria continued, and the problem of air-borne infection has now come again to the forefront. Recently, there have been advanced new facts, based on controlled observation, that air-borne infections take place in occupied rooms. It has been established that the number of micro-organisms in the air is higher in small and poorly ventilated rooms. The air in surgical operating rooms is also not germless. It may introduce infection into surgical areas, not unlike infection resulting from contact with unsterile material—dressing, gowns, gloves, instruments, water, and solutions. Almost all pathogenic bacteria found in the air come from human discharges. They are disseminated by coughing, sneezing, and even by mere breathing. They are said to be responsible for the spreading of a large number of diseases, which include the common cold, influenza, pneumonia, tuberculosis, cerebrospinal meningitis, poliomyelitis, and other diseases. They may be more correctly called spray-borne diseases, and are a source of greatest danger over a distance of a few feet from their source. While the potential danger of infection is decreased with the increase in distance between the infector and the infectee, the danger does not disappear entirely, for it has been observed that droplets may dry, retaining bacteria and remaining suspended in the air long enough to be carried far away from the source.[1]

The Author

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Supervision of Technics and Procedures

Satisfactory control of the spread of infection calls for constant supervision of technics and procedures wherever performed. Supervision should begin in the admitting office and extend widely over all hospital areas. Its concern should be:

Policies and practices related to inadmissible diseases

Steps taken in pre-admission physical examination of patients

Practices regarding pre-admission nose and throat cultures in children, and vaginal smears in girls

Clinical and age segregation of patients, and the assignment of all children and those adults suspected of having contagious disease

[1]Yaglou, C. P. Physical and Physiologic Principles of Air Conditioning. Journal of the American Medical Association. May 15, 1937. P. 1708.

to an observation ward for a reasonable number of days, before admission to a regular ward

Vigilance over practices applicable to patients in the hospital who developed or are suspected of having contagious disease—their isolation, care and disposition

Crowding in wards

Performance of surgery for apparently non-septic conditions in "clean" operating rooms, and for infected conditions in "septic" operating rooms

Schedule of operations, that is, the performance of surgery for known septic conditions after the completion of "clean" operations

Rules for hand cleansing and masking of surgeons and nurses

Unnecessary traffic, and routing of visitors to surgical operating rooms and to observation galleries

Purification of air

Exposure of patients to maximum sunshine and controlled ventilation

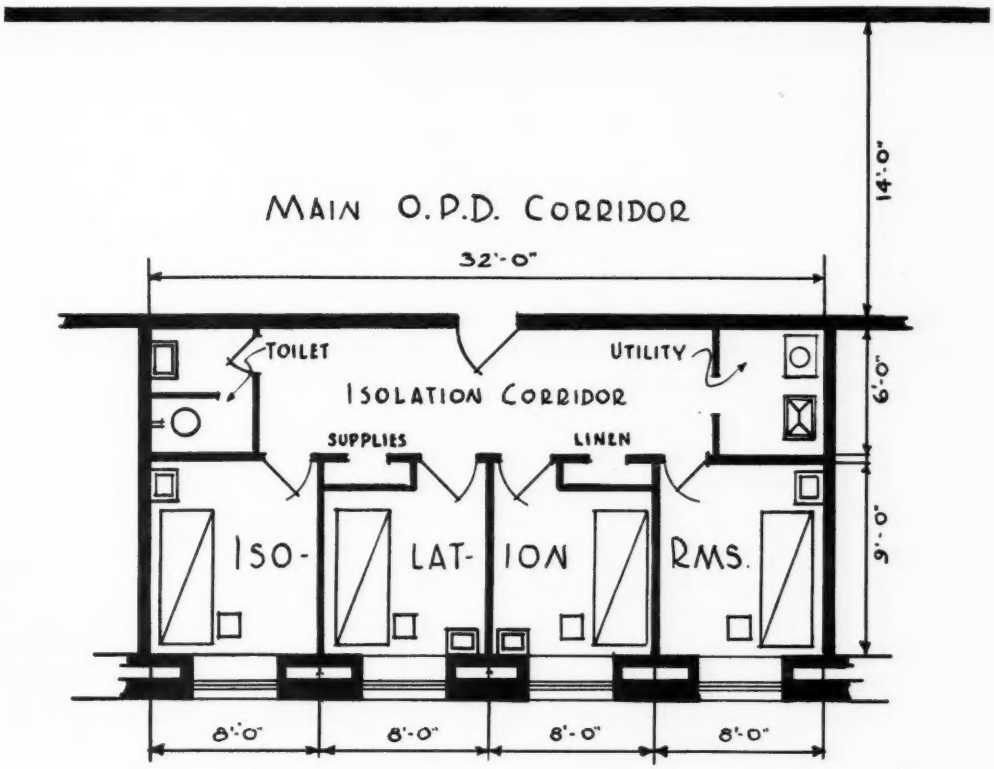
Periodic bacteriologic examinations of sterile material, water and solutions, surgeons' and operating room nurses' hands and nails, and when occasion requires the nose and throat

Periodic physical examinations of personnel, guarding against "carriers"

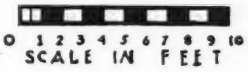
Study of untoward surgical results, of occurrence of pandemic and epidemic infections

Other procedures and technics, the safety of which depends on adequate precautions to be taken in surgical operating rooms, in the obstetrical division and in the nursery

From proper supervision many worth while experiences are gained and highly instructive lessons are learned, which, when made known to the medical staff and personnel, would result in greater caution and improved methods. The experiences would also lead to the preparation of intelligent



ISOLATION UNIT
FOR AN
OUT-PATIENT DEPARTMENT



and enforceable rules and regulations governing technics, procedures and practices, as they are to be performed—without break in asepsis and without causing the spread of infection. Finally, there would follow preparedness for timely application of controlling measures of established merit early in the discovery of infection that threatens to spread.

Detecting Faulty Equipment

The "routine" duties of the chief engineer, supervisor of nurses, head nurse of the surgical operating suite, the administrator and his assistants should include inspection, detection, and investigation of faulty equipment. They should be sufficiently informed on the technical construction of sterilizing equipment and what is expected of its performance to insure complete sterilization. This would include periodic testing of automatic instruments, and other controls of the efficacy of the equipment. The hospital's plumbing system and plumbing fixtures should be carefully examined and tested for contamination by back syphonage. The condition of laundry equipment and the efficacy of the work, as well as the handling of soiled and clean linen, should be periodically investigated. Vigilant and constant attention to these and other related problems is an important aid to the task of eliminating sources of infection.

The Germicidal Effects of Sun Rays

The ultraviolet rays of the sun are capable of destroying pathogenic and non-pathogenic bacteria. When bacteria are exposed to the sun they may be completely destroyed, or their activity and virulence may be reduced by the heating and drying effects of its rays. Experiments with ultraviolet lamps, the rays of which are thrown as barriers across a corridor separating infector from infectee, in order to eliminate transmission of infection by air, have shown in one case ". . . less cross infection than had occurred in previous years." The investigators suggest that "The efficacy of ultraviolet radiation in sterilizing the air of wards should be subjected to more extensive trial."[2] Then, also, ultraviolet irradiation of water in swimming pools has shown germidical value.

The germicidal value of sun rays is undisputed, hence there are advantages in frequent exposure of patients, bedding, clothing, and furniture to sunshine.

Sustained Maintenance of Efficient Ventilation

Hospital ventilation depends upon area, ceiling height and the flow of fresh air. Wide areas between beds, adequate number of cubic feet per patient, and sustained regulation of the flow and quantity of fresh air reduce the threatening danger of air-borne infection in occupied rooms and wards. Since the occurrence of infection of "clean" wounds exposed to infected air has been established experimentally, ample area and cubic content and efficient ventilation are also essential in surgical operating rooms.

Ventilation, natural or mechanical, dilutes and expels pathogenic organisms from occupied rooms and wards. It also gives patients physical and physiologic comfort. According to one observer, it overcomes "the increased temperature and humidity caused by heat and moisture given off from the skin and lungs of the occupants."

Ventilation requires special consideration in hospital planning and administration. The first involves: the proper orientation and exposure of buildings; location and arrangement of rooms and wards; size, type, and location of windows, doors, and transoms in relation to beds, that would aid ventilation, and at the same time avoid drafts; and the installation of mechanical ventilators. The second imposes a responsibility on the hospital administrator not only to maintain these physical conditions in efficient working order, but also to instill into the hospital personnel habits and practices which will keep areas adequately ventilated.

[2]McKhann, C. F.; Steeger, A.; Long, A. P.: Hospital Infections: Survey of the Problem. Am. J. Dis. Child 55:580. (March) 1938.

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Single copies may be secured for 30 cents a copy.

Food Problems in Pleasing the Patient

KATHERINE MARIS

DIETARY journals and lecturers on dietetics have continuously stressed the importance of organizational cooperation and the necessity for economical and efficient staff organization. Moreover, they have emphasized the importance of economy in buying and preparing food and a host of other purely technical phases relating to the management and care of a hospital culinary department. On the other hand these same lecturers and writers have almost completely neglected the all important problem of pleasing the sick patient. This is indeed an unfortunate situation since in my opinion one of the most important duties of a hospital dietary department is to learn and practice the art as well as the science of satisfying the sick and thus rendering a truly important curative therapeutic service to ailing patients. Too often we go sublimely along in our daily routine seemingly oblivious to the fact that good food and good service may be even more valuable than medication in the treatment of certain types of illness.

Certainly the majority of patients when they enter a hospital are not normal either physically or emotionally. They enter because their physician has definitely decided that they need hospital care. Many patients are in pain, and not infrequently they fear coming to the hospital because of the pathology that may be found when they are examined. Quite often the hospital patient is upset over his economic condition and may be in a highly nervous state. Since time immemorial the influence of emotional factors on the elaboration of digestive juices has been clearly recognized. For a hundred years physiologists have been obtaining scientific data to prove the influence of emotion on digestion. Thus, often the sick have badly jaded appetites and a stock answer, when many are asked what they would like to have to eat, is "Nothing." So it is our problem to see that the food is so prepared that it will be tempting and served daintily. This may be doubly difficult when the diet is restricted. Patients who are on restricted diets should never be allowed to feel that day in and day out they will have to eat the same food. If a little time and thought are spent the same articles of food can be so changed that they will look and taste good to one who is sick.

The Author

● **Katherine Maris is Chief of the Nutrition Department of St. Luke's Hospital, Kansas City, Missouri.**

The Value of Selective Menus

With the use of selective menus for general and soft diets, patients are often more easily satisfied since this gives them an opportunity to vary the menu themselves, thus greatly adding to their enjoyment. There are individuals who do not wish to be bothered or consulted about selecting food from a menu. These people will often eat and enjoy food with greater pleasure if some one else takes that responsibility. In such instances, the dietitian or the diet nurse on floor service may render invaluable assistance by checking the menu for these particular patients. Even the most dissatisfied patient may be pleased if visited frequently and special interest and tact are shown in respect to his particular dietary problem. For that matter who is it that does not enjoy special attention?

Menu Making

Menu making is another very important procedure, and should include the planning of a well balanced meal with the correct color scheme. Each meal should include proper portions of carbohydrates, proteins, fats, minerals and particularly vitamins in order to secure an accurate balance but after all it is the preparation and service of food which decides whether or not it will appeal to the patient. A check on the returned tray from the patient and a visit to this patient if food is left on the tray will very often solve a food problem and eliminate further trouble regarding the task of pleasing the patient.

In visiting one patient I found he was dissatisfied with one item of food, "graham crackers," therefore I asked him which brand he wished me

to order and in checking up I found that it was a second grade graham cracker that he desired. This was the brand he was accustomed to hence this very trivial alteration pleased him greatly and he then felt that we served the best of everything.

The Problem of Special Diets

It occurs quite frequently that patients who are on special diets cannot understand why they must eat only certain items of food because all of their lives they have been able to eat everything they wanted and even after a careful and thorough explanation they are still unable to understand. Such patients have said to me, "Just give it to me and I will not tell the doctor." We are often accused of catering to a patient's requests even though it may be against our better judgment. A patient of ours came to us on a bland-low residue diet but she was still able to eat oysters with horseradish and catsup so we served them to her and they did not hurt her. Whenever anything special is served to the patient he thinks that a personal interest is being taken in his case, which frequently results in an easily satisfied patient as long as he remains in the hospital. What is more pleasing to a dietitian than to hear directly or receive from a patient a note relating how much he enjoyed his stay in the hospital and especially how much he enjoyed the food? Being pleasant and interested in patients does not cost anything and goes a long way in solving their particular food problems.

Breaking the Monotony of Food Service

Another factor often overlooked in pleasing the sick is never to have set menus for certain days of the week. One must be constantly on the alert for something new or particularly good to eat. Furthermore food should be served in pretty dishes with nice silver on a neatly appointed tray in small portions attractively arranged. This will usually tempt a patient's appetite, whereas great quantities of food carelessly piled upon dishes often produces exactly the opposite result. If the floor service is used the employees in each diet kitchen should be carefully schooled to take an interest in the serving of their particular floor and all of their maneuvers should be carefully supervised. A patient who is getting what he wants and is pleased with his food is very apt to be satisfied in respect to other phases of hospital service.

Food is one of the main topics of conversation with everyone, sick or well, rich or poor. A recent instance comes to mind. A doctor who has a large free clinic receives as a chief complaint from a great many, "pain in the stomach." Further inquiry revealed that these people stated that they could not eat the food that was given to them at the Helping Hand Insitute (a charitable organization for the unemployed). So food complaints are found in every walk of life.

Cooperation of the Physician and the Dietitian

The hospital patient has no responsibility for his own care, that is, the physician orders the treatment and diet and the nurse and dietitian execute these orders. How often have we heard the doctor tell the patient he may have anything he wishes while in the hospital, that wish may be difficult or easy to fulfill according to the type of patient involved. Not long ago we had a man in the hospital who read the New York and Chicago papers and he asked for articles of food being consumed in those localities. When I was unable to get these particular items in Kansas City, I asked him what we could substitute. He remarked "I just wanted to see if you were trying to get what I asked for."

I remember very distinctly a woman patient who complained about our eggs, she wanted strictly fresh eggs. After a great deal of trouble one of the members of our Board of Directors said he would bring her some fresh eggs every day from his farm. Feeling very proud of myself I visited her the next day and asked how she enjoyed the eggs she had for breakfast and told her I had been able to get her some from the country. The reply was a stumper when she said, "How do I know they gather them every day?"

Helping the Patient in Making Hospital Adjustments

The average patient on entering the hospital finds it necessary to make adjustments to many things, and sometimes it is very difficult for them to become accustomed to the hospital meal hour schedule. Should we ignore the fact that sick and nervous patients are in the hospital for quiet and rest? Most certainly every consideration should be granted them as to the time they should be served. We are too often victims of a rigid routine that has gone on for years and years, as for example, a patient may be awakened and fed so that he may have his morning care out of the way before the physician makes his morning rounds. Quite frequently we have patients who are unable to sleep due to pain or nervousness and a sedative has to be given, we also have certain medical cases where sleep and rest constitutes the chief treatment. In these instances, the patient should be given the privilege of sleeping as long as

possible in the morning without being disturbed. The day slips by rather rapidly and before the patient realizes it, his evening meal arrives at a time that seems to be the middle of the afternoon. Furthermore, he is not far from wrong, "five o'clock." Whoever heard of eating at that hour when you are not going anywhere? Moreover, an afternoon nourishment has no doubt spoiled his appetite and he is not ready for his tray. Nevertheless he must try and eat, for the nurse has to give him evening care so he may be ready for visitors. Before retiring for the night he feels that it has been hours since he had that evening tray. Should he feel the necessity for something to eat at this time, a light nourishment should be served, which may enable him to have a more satisfactory night's rest. We frequently find that by the time the patient has made the necessary adjustments to set institutional rules and routine he is ready to go home.

Conclusion

In conclusion I would like to say that fortunately not all patients are hard to please. There are many who accept any food that is served and enjoy it and are even thoughtful enough to express their appreciation. This type of patient offsets the more severely critical and finicky individuals, which group constitutes the major problem of feeding the sick.

The hospital dietitian has a very big job. If she is to succeed she must have grit, ingenuity, tact and a sincere interest in sick people and in addition she must have the cooperation of the entire hospital personnel as well as the attending physician if she is to accomplish the task of having a well fed and a well satisfied patient.

Automobile Accidents Analyzed

Highlights from the annual report of The Travelers Insurance Company based on official records of the 48 states, include the following interesting facts:

Exceeding the speed limit was responsible for 36.5 per cent of the fatalities and 22.5 per cent of the injuries in 1939.

Nearly 40 per cent of all traffic accident victims were pedestrians.

Almost 87 per cent of the fatal accidents occurred in clear weather and almost 80 per cent happened when the road surface was dry.

More than 93 per cent of the drivers involved in fatal accidents were male and less than seven per cent female.

More persons were killed on Sunday than on any other day of the week, while the heaviest injury toll came on Saturday. Wednesday was the safest day for travel. The period between 7 p. m. and 8 p. m. was the most dangerous hour of the day.

The motor vehicle death rate, based on mileage, is at least three times as high by night as by day.

Pedestrian Dangers Stressed

The report views with growing concern the increase in automobile-pedestrian accidents, particularly in metropolitan areas at night, and devotes an entire section to the problems of the man on foot. One graphic illustration shows that while a man takes one step and advances one yard, an automobile being driven at 30 miles an hour advances nine yards. Another shows that a pedestrian in dark clothing is all but invisible to the driver at night a mere 100 feet away but is clearly visible in light clothing up to 200 feet or more.

Needles Sharpened

The Rochester General Hospital, Rochester, New York, reports the installation of a needle sharpener, and states it is one of the most appreciated of the recent additions to the equipment of the central supply room.

The apparatus consists of a carborundum wheel, with three degrees of abrasiveness, for grinding and finishing needles, driven at high speed by a small electric motor and an adjustable holder, similar to the tool-rest of a lathe, for holding the needles. The diameter of the wheel has been calculated to give a hollow-grind to the needles. The grinding and finishing are observed under a high-powered reading glass, thus making the detection of imperfections and burrs easy. The great improvement in the sharpness of needles prepared on this machine has been the subject of favorable comment by a large number of the staff.

American Heart Association, Inc.

The Sixteenth Scientific Sessions of the American Heart Association will be held at Hotel Roosevelt, New York City, June 7-8.

The general cardiac program will be given on Friday, June 7, and the program of the Section for the Study of Peripheral Circulation on Saturday, June 8.

The Hospital and the Intern

J. H. J. UPHAM, M.D.

ONE of the great developments in medical education in modern times has been the recognition of the important role of the hospital in that field of instruction. This conception nowadays is in the broadest sense, and includes teaching not only the medical student and the intern, but the practicing physician as well.

Every hospital worthy of the name today is a "teaching hospital" whether or not it is connected with a medical college. Anyone who considers that student days are over after graduation from a college of medicine has a very superficial view of the ideals and responsibilities of modern medical practice. By the present organization of staff meetings, record keeping, required necropsies, x-ray equipment, clinical laboratories and the multitude of other facilities for modern diagnosis and treatment, hospitals provide the means for the advancement in knowledge and skill to all of its staff.

Few if any practicing physicians could provide for themselves such a varied and extensive armamentarium that is necessary for present day practice, and yet this is furnished for the communal use of the staff members. The result is that the hospital today raises the plane of medical practice in its community, makes better doctors, and benefits every citizen.

Fascinating as is this field of thought, we must confine ourselves to the hospital intern and intern service. Many of us can remember when the seeking of an internship by the graduate was the exception rather than the rule. Of my own class which graduated in the "nineties," I doubt if half of its members sought such positions. The rapid advances of medical practice, however, began demanding more skill in the application of modern methods. Formerly a physician's armamentarium consisted of little more than a stethoscope, thermometer, and medicine case, but the entrance of the microscope, clinical laboratory methods, x-ray and other requirements demanded a working knowledge of them for which the hospitals afford excellent opportunity. Therefore, more and more graduates sought internships and more and more hospitals, finding the practice to their advantage, encouraged them to come to their institutions. For several years conditions were chaotic; many hospitals exercised very little supervision over their interns, often in fact exploiting them as super-orderlies, and on the other hand many interns exploited the hospitals for personal gain, and were either benefited or actually harmed by their hospital service according to luck or personal initiative.

The Author

● **Dr. J. H. J. Upham, Author, Physician and Educator, is Dean of the College of Medicine, University of Ohio, Columbus, Ohio.**

Role of the Hospital in Medical Education

The reforms in hospital surgical service brought about by the American College of Surgeons, and the inspection and requirements of the Council on Medical Education and Hospitals of the American Medical Association for approval for intern service have been most beneficial. Great progress has been made so that for some years several states have required internships for granting licensure and some colleges only grant diplomas to their graduates after a year's service in an approved hospital.

Last October the Association of American Medical Colleges passed the following resolution:

> "Inasmuch as the internship is now universally regarded as a part of the basic preparation for the practice of medicine and to be fully satisfactory must be integrated with the medical course proper, the Advisory Council on Medical Education recommends that the Association on American Medical Colleges in cooperation with national medical and hospital organizations and the Federation of State Medical Boards and state licensing bodies and after consultation with

Presented before the Ohio State Hospital Association Conference.

the Council on Medical Education and Hospitals of the American Medical Association should formulate minimum educational standards for the internship and should prepare a list of hospitals in this country which meet these standards."*

This is the very definite recognition by medical educators of the role of the hospital in the present program of medical education; they consider it an important and necessary continuation of college instruction, but by the stress given on intern service and the suggested program, this may stir up some antagonism. There may be some apprehension as to further inspections and added requirements; after all, while hospitals have been most cooperative as a whole in the educational program, the care of the sick is their primary interest and reason for existence. In this recent action of the Association of American Medical Colleges it may be thought by some that the hospitals are being relegated to the position of subsidiaries of the medical college.

A little thought, however, will, I believe, show that the objective sought will serve the interests of the hospitals and medical education. The hospitals seek skilled service for their patients, the medical educators seek that interns shall have opportunities for development of skilled service.

It is too early to say just how this program may best be worked out. It will have to be given earnest study and the many varying factors carefully considered. Personally, I am opposed to looking upon the intern as a fifth year student. The majority of our graduates have had eight years of college work and doubtless almost all of them must be weary of lectures, demonstrations, and the restrictions of student life. They are now doctors and seek actual contact with and observation of sick patients. They must be under supervision of course, but have a chance to develop initiative and confidence. They must write histories and records, but this done in connection with patients to a certain degree under their own care is vitally different. They must do laboratory work, but this should be restricted as much as possible to patients on their own service. In other words, as far as practical almost all of their work should be tied up with actual patients under their observation. They should be given increasing opportunities and authority as the individual intern merits, and in this the sympathetic attitude of the attending staff member is invaluable. Usually the intern responds wonderfully. When I was an intern, for the first few months my therapeutic authority was limited to the ordering of laxatives for my ward of 28 patients. I seized the opportunity with enthusiasm, and ran the gamut of all the laxatives and some purgatives that I had heard about in my lectures. I gained an excellent experience, and so did some of my patients. It did me a lot of good and did not do them any harm.

*HOSPITALS, March, 1940, p. 67.

Faults of a One-Year Intern Service

We have been giving this subject a good deal of thought for several years in the University Hospital, and have tried out various plans. Of course with us the educational idea stands out prominently because of our association with the College of Medicine. We found that one year's internship did not give a well rounded out service, and one not satisfactory in regard to hospital routine. The intern was too short a time in each area to gain more than a smattering of training and the frequent changes were disturbing to the hospital routine. We have therefore set up a two-year program planned to give more thorough training to serve either as a basis for entering general practice or for more advanced postgraduate work, and at the same time give the hospital more skillful service.

Optional Training Provided

This arrangement provides for a certain amount of optional training.

First Year—The ten new interns selected are divided into two equal groups, (a) medical and (b) surgical services.

a) Medicine, including general medicine, hematology, pediatrics and infectious diseases, three months each with laboratory work throughout the year in connection with each service.

b) Surgery, including general surgery, gynecology, genito-urinary diseases and obstetrics, each three months with laboratory throughout the year in connection with each service.

Second Year—The groups reverse the services. That is, those having had the surgical services now may take the medical and those having had the medical take the surgical services. Thus in the two years we feel they receive a well rounded out experience for general practice and remain long enough in each area to be more valuable to the hospital. There are some interns, however, who have definite plans of specialization in either the surgical or medical fields. For such we give the option of continuing in the second year in either medicine or surgery so that an intern may elect to take two years in either division.

In addition we offer a third and fourth year service.

Third Year—The third year is open to those who have completed two years with us or to those

having had a similar training elsewhere. These appointees have the title, assistant residents, and are apportioned as follows: two in medicine with six months in clinical ward and out-patient department service, and six months in medical, clinical and pathological laboratory work; nine assistant residents serve in the various surgical fields, for three of those most interested in pure surgery we offer a service of four months each in general surgery, research surgery, and genito-urinary surgery; for those desiring a more general experience we provide three months each in general surgery, gynecology, x-ray and emergency service, and surgical pathology; lastly, we have one assistant resident in the eye, ear, nose and throat division and one in surgical pathology for 12 months.

Fourth Year—For the fourth year our plan provides for six residents, selected from our own group of those having three years' training, or from elsewhere with similar training. There is one each in general medicine, research medicine, general surgery, research surgery, genito-urinary diseases and gynecology.

Frankly, I feel that our arrangement is a bit top-heavy as far as the hospital is concerned. However, our plan is based definitely on a post-graduate educational plane and our assistant residents and residents give aid in the instruction of students in the wards and out-patient clinic. Further, those in third and fourth year may register in The Graduate School of the University and upon presentation of an acceptable thesis, may be eligible for the degree of Master of Medical Sciences.

The Two-Year Resident

For the general hospital not connected with a medical college, the two year plan with a resident, preferably one for the medical and one for the surgical service, has many advantages for the hospital in quality of service and for the interns in better developing their skill and initiative. Every year I stress to the members of the graduating class that as in every practical field of activity in life, they will get in value out of their hospital service exactly in proportion to what they put into it. It is also true that the hospitals will get in service from interns the return in kind for what they give.

As I have indicated we endeavor to treat these young people as physicians in fact. They are assigned to definite areas with definite medical responsibilities for which they are accountable. Grand rounds are made once a week with the attending staff member and cases are discussed by the entire group. At each monthly staff meeting an intern presents a case history with comments, and it is discussed by other interns and staff-members present,—just as in any medical society meeting. At the weekly clinical pathologic conference, interesting necropsy reports are presented by members of the intern group and the clinical history, diagnosis, and treatment detailed. Then the case is open for discussion by all present.

Attendance upon and participation in necropsies is required, and records are kept of all the necropsies obtained by each intern and interest stimulated in securing necropsies by prizes awarded to the interns most successful in that endeavor.

Discipline as Applied to Interns

Discipline of interns is of course necessary at times, and while firmness is needed, it should be exercised with judgment and tact. It is my belief that the more the young graduate is treated as a responsible member of the medical profession the better he will respond.

The attending staff-members bear a great responsibility in this, and by their attitude, interested or apathetic, by their example toward the treatment of the patients, painstaking or slipshod, or by their exhibition of skill or ignorance in medical practice and ethics they may make or break an intern.

The whole problem is one of proper recognition of individual responsibility and a correlation of the various factors. The general scheme of internship should be good for the intern, for the hospital and for the attending staff. Where trouble arises the case should be carefully studied and a true diagnosis established. If the trouble is a sporadic case, the individual intern may be at fault, and like a painful tooth the only successful treatment may be a necessary extraction. In other cases the hospital or the attending staff may be at fault. In all cases the administrator of the hospital should have final powers but he must have a thorough conception of the objectives of intern service, and a human interest in the young individuals seeking improvement in skill for their future life work.

All factors concerned, medical colleges, licensing boards, hospitals, staff-members and interns must be brought to the recognition that full success of intern services rest upon the supporting tripod of the attitude of the hospital, the staff, and the intern; weakness of any one endangers the entire structure in any individual hospital. Tact and judgment are essential in the administration and in the proportion that they are exercised to bring about cordial cooperation and harmony among all concerned, just so far will be best served the interests of all.

The Small Hospital and Its Principal Problems

JEWELL WHITE THRASHER, R.N.

IT IS obvious that within the next few years our small hospitals face a prodigious number of problems. If the curriculum guide is followed verbatim, our small hospitals will have to close all of their schools of nursing. And even at the present time there is a shortage of nurses who have the training necessary for the small hospital. The stress on theory, and the requirement of more hours in the classroom for the student nurses, bring up the problem of bedside nursing. We must admit it is necessary to have the student nurse care for the patient. If we give her all the required hours in the class room, it means a larger nursing staff and increased graduate nurse service, with a definite increase in expense. With this added expense, the small hospital, already straining under its load, cannot carry the extra financial burden of a school of nursing.

The Place of the Subsidiary Worker

The American College of Surgeons gives us a gentle warning against using, for the sake of economy, too many subsidiary workers or practical nurses. These workers, though they do have a definite and invaluable place in the hospital, cannot be used for actual nursing care—they cannot substitute for nurses.

Combination of Duties Necessary in a Small Hospital

The nurse trained in a large hospital, and not familiar with a combination of duties, finds it difficult to adjust herself to a small hospital. For example, she may be called to help with a delivery, then enter the operating room to help with an operation; after which, she will probably assist with a plaster cast or with an emergency that has just arrived. All this is entirely familiar to the nurse trained in a small general hospital.

No one but the small hospital administrator knows the problem of trying to help the nurse trained in a large institution adjust herself; and to help relieve the unhappiness she has in adapting herself to the diversity of work in a small hospital.

Presented at the Southeastern Conference.

The Author

● **Mrs. Jewell White Thrasher, R.N., is the Administrator of the Frasier-Ellis Hospital, Dothan, Alabama.**

The Specialization Trend

The present trend in the medical profession is specialization. It has had its effect on the nursing profession. Since the doctors are specializing, why shouldn't we? There are some branches of specialization in our profession—why not advance something new and specialize in small hospital work? Above all, it will require a working knowledge of every department and how to adapt one's self to each or any of these departments on a moment's notice.

We may receive the salary and rank of a supervisor, but many times we may find ourselves doing the menial tasks, since there is not always a maid or an aide available. We need and welcome those whose training fits them practically and psychologically for the small hospital.

The Small Hospital's Financial Problems

The financial side of the small hospital has always to be borne in mind. We must be constantly on the alert to see where we can improvise cheap equipment that can be used in place of the more expensive type. There are certain supplies, as well as equipment, that cannot be improvised or cheaper substitutes used. This brings up the point of knowing and purchasing the quality and quantity required for our use. We cannot take a chance on quality so we purchase our supplies from reputable concerns and limit our shopping for prices among those we know. This has its advantages and disadvantages. But we must always keep in mind that it is not always the lowest price that is the cheapest for the hospital.

Though quantity buying is certainly economical, we doubt the wisdom of tying up large sums on a few items when it would mean the budget

would prohibit further buying of other items that may be just as necessary as those in which we have invested.

The small hospital cannot enjoy quantity buying on the same basis as the large institutions. It is rare that we can ask for bids and get this advantage of price. There are special supplies at certain seasons that usually reach a low level, and at this time it may be wise to buy several months', or even a year's, supply.

Purchasing for the Small Hospital

Too much of our buying in small hospitals is done in a very haphazard manner. The departmental heads should be consulted concerning new types of supplies and equipment, but the buying must be done by the administrative officer, or one person trained to do it. The possible exception to this rule is the buying for the dietary department. The dietitian, by virtue of her training, is better able to market and get value received for her own department than anyone else.

Requisitions should be signed by the departmental head and approved by the administrator. There should be a time limit each day for these requests to reach the administrator's desk for approval. For the larger supplies, there should be a certain day each week designated for these to be filled, following the same procedure.

In many places, requisitions are considered of no value, since the administrator feels she knows the needs of various departments and fills the supplies according to her own judgment and memory. This often proves an expensive method of buying. Also, it causes much loss of time to the administrator in frequent trips to storage or supply rooms. There may be doubt as to the real value of the perpetual inventory in the small hospital, provided the requisitions and distributions have been done in a systematic manner. The wise administrator can soon anticipate the hospital needs from her records of requisitions, orders purchased, and supplies distributed. There should be an annual inventory of all supplies regardless of whether or not a perpetual inventory is kept to be sure it checks with supplies on hand.

Departmentalization in the Small Hospital

One of the problems peculiar to the small hospital is the growing necessity for departmentalization. Departmentalization has come with specialization which only a few years ago was confined to the large institution. Due to the arrangement of many of our buildings, it is rather difficult to segregate patients of a certain type since in the construction only ward and private patients were thought of, without any special diseases or condition in mind. Isolation of cases is rare, with the exception of the occasional diphtheria, meningitis, or highly communicable diseases that may occur. Usually one room is so arranged that it may quickly be used for isolation. There are few small hospitals that have an isolation unit. The cost of handling isolation cases is almost prohibitive, since so many special duty nurses are required to carry out the precautions necessary for the safety of the other patients. The only consolation we have is that the instances of cross infection are rare.

At the present time our small institutions are well equipped for every diagnostic phase, though they may have to refer some of their cases to the larger institutions, or a special clinic, for treatment. This is particularly true for deep-x-ray and radium, the cost of which is prohibitive to many of us.

Cooperation for Good Clinical Records

A difficult phase of administration in small hospitals is that of obtaining the cooperation of the staff in providing good clinical records. The professional work of a hospital is appraised by the type of these records. In the small hospitals there are no interns or residents to write them. This must be done by the attending physician. Moreover, almost all of the records have to be written by the busiest doctors. Dr. Rankin, of Duke Endowment, has said that the doctor in the little hospital must practice what the doctor in the big hospital preaches—the art of keeping good records of his cases. The hospital itself, then, though small, is obligated to help the physician obtain his records, thereby requiring a minimum of his time. This has been accomplished by various means—such as, stenographers, dictophones, and occasionally, senior medical students when the hospital is accessible to a medical school.

Collections

The problem of collections is not entirely confined to the small hospitals, but is one in which their administrators are likely to be concerned more frequently than the administrators in the large institutions, since the majority have to use their judgment, without the aid of a social service worker, as to the patients' ability to pay. It is here that the administrator finds herself most severely tested. Many of us find ourselves between the devil and the deep blue sea trying to please the public and grasp the financial situation of the patient on one hand; and trying to show our Board of Managers a record of good collections, on the other. We must be neither too strict

nor too lenient. There is not yet, so far as I know, a hard and fast rule that can be adhered to strictly.

Although it is a good policy to have some understanding about finances as soon as the patient arrives—weekly payments in advance are advisable—no patient should be left suffering awaiting the arrival of someone to assume financial obligations.

Bookkeeping in the Small Hospital

No one can make wise expenditures or show records of collections without a good bookkeeping system. Monthly audits are to be recommended rather than annual or semi-annual ones. It is only by this means that we are able to know how we stand. The auditor is a protection both for the bookkeeping department and the Board of Managers. The use of friends with bookkeeping knowledge, doing this work as a friendly gesture, is questionable from a business standpoint. Employ and pay a certified public accountant to do the auditing, and his report will more than repay the cost by the feeling of confidence and assurance and good credit rating his signed report gives.

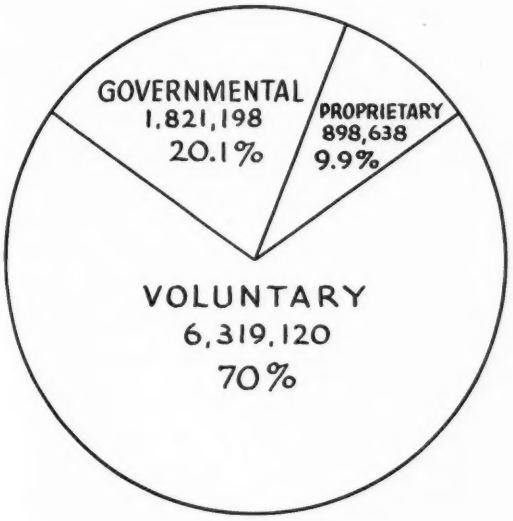
Cooperation with Correlation

In closing I would like to mention cooperation and correlation. They are essentials in any organization, regardless of size; but they are more likely to be ignored in the small hospital due to the fact we have to combine the duties of various departmental heads. We cannot take the human elements out, therefore they must be considered as well as the mechanical ones; and wherever there are combinations of duties there is likely to be overlapping. This causes friction and antagonism which breed discord and hinder the effective and efficient mechanism of the institution. Each worker should understand her responsibility, and should be vested with the proper authority to successfully fulfill these duties entrusted to her. The organization must be flexible enough to allow individual initiative and to foster individual resourcefulness. Hence, the need for cooperation is great but the need for correlation is greater. While we do not want overlapping of duties, interrelationships must be clearly defined; and certainly every phase of the hospital work must be covered with great care taken that no minor detail is left for which someone is not responsible.

GENERAL HOSPITALS 1939

· BY OWNERSHIP ·

ADMISSIONS



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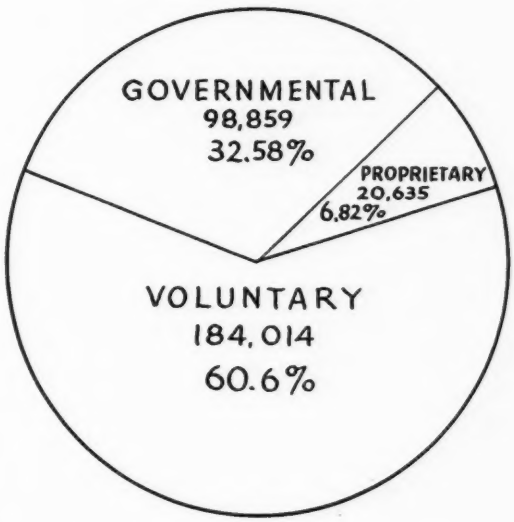

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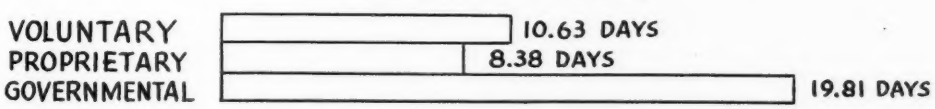

The Hospital Credit Union

EDWARD C. WATTS

IN the United States in 1938, there was a total of 6,166 hospitals, sanatoriums and related institutions which were registered by the Council on Medical Education and Hospitals of the American Medical Association. These institutions had a bed capacity of 1,161,380 patients and undoubtedly an employee group of approximately that same number. According to recent statistics of the Credit Union National Association there were among this entire group of hospital organizations less than fifty which were sponsors of credit unions among their employee groups. The credit union movement is such an important factor in helping to maintain the morale and stability of an employee group that it seems unfortunate that greater use is not made of it by the hospitals of this country. Any one who is familiar with hospital organization and who understands the credit union movement knows that there is a large group of hospital employees who would derive great benefit from hospital credit unions.

The Author

● **Edward C. Watts is Chief Pharmacist of St. Luke's Hospital, New York City. Previous to March 1, he was Assistant Chief Pharmacist of the University Hospital, University of Michigan, and Treasurer-Manager of the University Hospital Employees' Credit Union.**

What Is a Credit Union?

For the benefit of those who are not entirely familiar with the term "credit union," the definition given by Bergengren in his book *Cuna Emerges* may be of interest. "A credit union is a cooperative society in the business of supplying its members with cooperative credit. It accomplishes this end by first furnishing its members with the machinery which enables them to accumulate savings in a common pool. These savings the members of the specific group manage through officers chosen by and from their own number. The money is invested in loans to members of the group exclusively, and only for provident and productive purposes, and at reasonable rates of interest. All of the net earnings (after the expenses of operation have been paid and 20 per cent of the net has been set aside as an indivisible surplus) are divided among the members of the society in question as dividends on their savings in the common pool. *There is no exterior capital and no one outside the specific group in question may have anything to do with the credit union in question directly or indirectly.* In all matters each member has a single vote, whatever his share holding."

The High Cost of Small Loans

By many who are most familiar with social and economic conditions of our present age it is considered that one of the largest and most successful bootlegging enterprises is the nefarious practice of making small loans at usurious rates of interest. According to recent estimates of the Russell Sage Foundation, people who find themselves suddenly in need of small loans were 100 million dollars in debt to loan sharks at the end of 1937. As one example of the enormity of this usury the Public Affairs Committee presented the case of a Dallas, Texas, resident who, in need of $20.00, obtained it from a loan shark in November, 1929. He agreed to repay at the rate of $2.25 per week. In November, 1938, nine years later he was still paying and still owed more than the original loan. During these years $1,053.00 had been expended in an attempt to return a loan of $20.00. The interest rate if calculated is about 585 per cent per year.

The Development of the Credit Union at University Hospital

Although the State of Michigan is fortunate in having a small loan act which affords some protection against the worst of the loan sharks the situation is still aggravating enough so that there are over two hundred credit unions operating within the state. Early in 1938 a small group of employees at University Hospital decided to attempt to obtain further relief and protection from

excessive loan rates by organizing a credit union in accordance with the state credit union act. In March, 1938, a charter was received from the State Banking Commissioner and with an initial subscription of about $300.00 the books were opened. A drive for membership resulted in the enrollment of 69 members by the end of the third month. At the end of 1939 there had been 148 pass books issued. Due to an unexpected lowering of the hospital's census in mid-summer, 1939, many employees were forced to seek other employment and consequently the membership of the credit union declined. The actual membership, as reported to the State Banking Commissioner, on December 31, 1939, was 119. This group at this time had invested in shares in their credit union to the extent of $2,004.25.

Applications for loans were first accepted during April, 1938, the second month of operation. A total of 194 or an average of approximately nine loans per month have been made since organization. These have been for a variety of purposes and it is only when reviewing the applications for these loans that one becomes fully appreciative of the value of a credit union to a group of hospital employees. Money is made available with a minimum of delay and at the very favorable rate of one per cent per month on the unpaid balances. Although all must be made for provident or productive purposes, this definition is capable of broad interpretation as can be seen when the following reasons for borrowing are reviewed:

Consolidation of small debts
Payment of insurance premiums
Payment of hospital accounts
Purchase of furniture

University Hospital Employees' Credit Union Financial and Statistical Report
Month of December, 1939

BALANCE SHEET

Assets	*End of This Month*	*Same Month Last Year*	*Liabilities*	*End of This Month*	*Same.. Month Last Year*
Loans	$1,979.93	$1,095.50	Notes Payable	.....	$ 200.00
Cash in Banks	27.35	214.96	Shares	$2004.25	1,075.45
Petty Cash Fund	5.00	5.00	Reserve for Bad Loans	103.94	33.31
Cash Reserve	59.81	.....	Undivided Profits	20.29	.....
Central Credit Union	150.00	10.10	Profit and Loss	93.61	20.29
Accrued Interest	.....	3.49			
Total	$2,222.09	$1,329.05	Total	$2,222.09	$1,329.05

Statement of Income and Expense

Expenses	*This Month*	*This Year to Date*	*Income*	*This Month*	*This Year to Date*
Interest Paid on Borrowed Money	....	$ 8.38	Interest on loans	$13.21	$182.70
Stationery and Supplies	....	5.44	Entrance Fees	.50	12.50
Advertising	....	3.13	Fines	.50	29.65
Misc. General	$ .05	43.66			
Trans. to Reserve for Bad Loans	1.00	70.63			
Balance (Profit)	13.16	93.61			
Total	$14.21	$224.85	Total	$14.21	$224.85

Statistical Report

Loans	*No.*	*Amount*	*Shares and Members*	
Made this Month	9	$ 415.00	Paid in Shares this Month	$ 37.80
Repaid this Month	..	350.74	Withdrawn on Shares this Month	61.00
In Force at End of Month	..	1,979.93	Total Paid in Shares Since Organization	2,755.50
Total Loaned Since Organization	..	10,479.43	Total Withdrawn on Shares Since Organization	751.25
Loans Delinquent	22	218.59	New Members this Month (number)	2
(A) One Month or Less	..	91.50	Total Members End of Month	119
(B) One to Two Months	..	40.58		
(C) Two Months or Over	..	86.51	Total Members Since Organization	148
Charged Off this Month	..	None		
Charged Off Since Organization	..	None		

H. H. KELSEY,
BERNARD E. RICHMOND,
A. J. SULLIVAN,
Supervisory Committee.

EDWARD C. WATTS,
Treasurer.

Purchase of automobile
Purchase of lumber, shingles, etc.
Payment of tuition
Travelling expense due to illness
Payment of doctors and dentists bills
Payments on home
Living expenses during illness
Necessary vacations
Refinance loans with loan companies
Assist relatives
Purchase clothing
Drill a well
Funeral expense
Buy coal
Purchase property at tax sale

All of these reasons are legitimate and there has been little or no attempt made to misuse the loan feature of the credit union by the members. In several instances the University Hospital Employees' Credit Union has already been of very much assistance to employees who suddenly found themselves embarrassed financially.

How the Money Is Loaned

Although permitted by law to loan as much as $300.00, to any one person, the majority of the loans, which have been made by the University Hospital Employees' Credit Union, have been for amounts of fifty dollars or less. Larger loans are becoming more frequent as the credit union grows and the members and other hospital employees realize what the credit union can do for them. The loan features of the credit union should not be emphasized to the exclusion of the savings and earning features. The credit union because of its cooperative nature and the cohesiveness of the group of employees who are members is, as national statistics have proven, a very safe place to save and invest earnings. Almost all credit unions which have been in operation for two years or more are able to declare regular yearly dividends of from four to six per cent. The University Hospital Employees' Credit Union, which at this time has been in operation less than two years, was able to declare, at the end of 1939, a dividend of three per cent per annum for the entire period of operation. A complete financial and statistical report as of December 31, 1939, is appended.

The Interest of Large Corporations in Employees' Credit Unions

Credit unions have been sponsored by many of the largest corporations of this country. The Bell Telephone Company, Armour and Company, Swift and Company, many of the automobile factories, and various units of our Federal, state and municipal governments are representative of those who

University Hospital Employees' Credit Union
Memorandum of Dividend

January 31, 1940.

To

The Board of Directors of the University Hospital Employees' Credit Union, at the regular meeting held on January 10, 1940, declared a dividend of 3 per cent per annum for all shares as of record December 31, 1939, to be computed according to the number of months such shares have been held and payable as of this date, January 31, 1940.

Your dividend in the amount of —— has been credited to your share account.

EDWARD C. WATTS,
Treasurer-Manager.

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are encouraging the credit union movement. In the great majority of cases the credit unions so sponsored have been quite successful. The largest credit union in the state of Michigan is a teachers' organization and has assets of over a million dollars. That other credit unions are being successful, but in a smaller way, is made apparent by the annual reports of the Credit Union National Association. These indicate a substantial gain in the total number of credit unions each year.

The Work of Edward A. Filene

The late Edward A. Filene, of Boston, must be given much credit and praise for having spent so much money, time and effort to promote the cause of the credit union in the United States. The Credit Union National Association in attempting to raise funds for the construction of a national headquarters building to be known as Filene House is to be commended and encouraged in every way possible. Almost every state in the Union now has a credit union act enabling employee and other groups to organize and assist themselves in overcoming some of the financial difficulties of today. For those states which do not have enabling acts and for those groups which prefer the supervision of the Federal Government there has been established, in the Farm Credit Administration, a means whereby Federal Credit Unions may be established. It would seem that the hospitals of America, whose employees need the credit union facilities as much or more than any other group of employees today should take a greater interest in the establishment of these organizations. Hospital administrators who are interested may obtain full information from the Managing Directors of the various state Credit Union Leagues, the Credit Union National Association, Madison, Wisconsin, or from the Director, Credit Union Section, Farm Credit Administration, Washington, D. C. It is to be hoped that the Credit Union National Association will be in a position within the next year or two to report a substantial gain in hospital credit unions.

How the Modern Laboratory Aids Medical Science in the Treatment of Disease

HARRY A. BARNES, M.D.

AS IN ALL branches of human knowledge, tremendous progress in medicine and surgery has been made in the past few decades. The allied sciences of physiology, biochemistry, bacteriology, and pathology have introduced methods of precision in the study of disease. With a knowledge of the natural history of disease, the daily use of instruments of precision and diagnostic laboratories, what was once an art has gradually evolved into a science.

The dependence of the modern physician and surgeon and specialist, as well as the general practitioner, upon the laboratory becomes greater as knowledge progresses, and with that, emphasis has been gradually placed upon the "whys and wherefores" of disease processes. The physician today can no longer rest content to be merely a passive observer; he must act promptly, and with assurance. To do so, he must have at his command a precise working knowledge of all the methods available to aid him in the discovery of the causes of disease, and in the institution of proper specific therapeutic measures.

The "Clinical Laboratory" Defined

The question may be asked: What do you mean by the term "clinical laboratory"? In brief, a clinical laboratory is one in which chemical, physical, and biological methods are applied to the study of disease. It may be a research laboratory in pure science, but it is essentially a laboratory of applied science as it relates to medicine and surgery.

A survey of ancient medical writings will disclose the fact that the ancients were well versed in the examination of the pulse, the tongue, and the ejecta. They often consulted the stars, the flights of birds, and noted any incidental occurrences during their visits, thus making diagnoses of disease processes from varying circumstances. Their methods of precision were crude, having only the ordinary senses and the unaided eye. It is true that the eye can be eventually trained to see slight irregularities, the ear may detect faint murmurs, and the fingers can often feel a slight resistance, but these changes are at times most deceptive, as many a physician has learned to his chagrin at the necropsy table. Admittedly then, there is no degree of art or passive observation that can equal in its precision an *agglutination test;* a study of the cells and chemical composition of the spinal fluid, or the finding of the tubercle bacillus in the urine or sputum of an individual suffering from kidney or lung tuberculosis. Often the Widal Test indicates typhoid fever much sooner than does the clinical chart; the dark field examination and Wasserman reaction disclose syphilis more readily than does the history and physical examination. Blood cultures will isolate poisonous organisms long before abscesses will appear. Various forms of anemia, leukemia, and malaria can only be diagnosed specifically by the laboratory. To mention other conditions, there are trichinosis, malta fever, tularemia, and a host of others too numerous to mention. One needs only to ask: Which will diagnose a small tumor accurately, a microscopic section or a description of its consistency, fixity, and invasive properties? The answer is obvious to everyone—the microscopic section.

Sir James MacKenzie, a very sensible, able, and clear thinking English physician of the late eighties, stated very early after the half-hearted acceptance of the "germ theory of disease," that the symptoms produced by each germ or microbe should be recognized by the doctor who sees the patient. Unfortunately, however, different organisms induce the same type of symptoms during the early stages of different diseases. It is at this point that the laboratory is of pertinent value to the physician or surgeon. It is always well to remember that the first appearance

The Author

● **Dr. Harry A. Barnes is Associate Surgeon and Director of Clinical Laboratory, Flagstaff Hospital, Flagstaff, Arizona.**

of disease in the human body, other than the appearance of the unforeseen catastrophic emergency, is usually insidious, with little disturbance of the body economy. A disease is of so little concern to a patient unless symptoms develop. The advent of symptoms makes possible recognition of the condition, but frequently too late for the application of specific therapeutic measures.

Again one needs only to ask which is more certain—the uncertain rose spots or the blood culture and the Widal Test, the presence of itching in diabetes or the blood sugar determinations, inspection of an ulcer or the Wasserman reaction, the smell in a patient's room or the smear and throat culture?

The Significance of Blood Studies

I am sure the laity has heard enough of the "white count" with reference to that popular modern disease called appendicitis. This simple counting of the number of leucocytes is often of incalculable value both from the standpoint of diagnosis and estimation of the outcome of disease. The relationship existing between inflammatory disease and the number of circulating white cells expresses a ratio or proportion indicative of the intensity of the local existing infectious reaction with but a few exceptions.

Given a child who becomes suddenly stricken with ill-defined symptoms; the temperature is high, the pulse is accelerated, the respirations increased, but only in direct proportion to the height of the fever; the physical examination yields little. The first, second, and third day passes, and even a greater length of time may elapse before a diagnosis can be made with any certainty. In just such cases, the value of blood studies becomes apparent, as the existence of a well marked increase in the circulating white cells will probably give the diagnosis and, it might be said, the prognosis as well.

As you no doubt have guessed, this illustrates a typical case of pneumonia. But to go further, what type? To that end the typing of the pneumococcus is of inestimable value in the arrangement of treatment from the standpoint of serum therapy.

Casual Factors Determined in the Laboratory

Among the commoner diseases with which the laity is acquainted, I need only to mention a few that come under the caption of just plain "everyday sore throat." Without the aid of the laboratory methods of accurate diagnosis, prevention, treatment, and epidemiological control would be in a state of great confusion. Under the common complaints of sore throat, there are, diphtheria, scarlet fever, acute tonsillitis, trench mouth, leucemia, states of vitamin deficiency, agranulocytosis, syphilis and a host of others, each having as one of the outstanding symptoms "sore throat," but differing in their causitive agent, the course pursued by the disease, and the termination of the disease. For accurate differentiation smears, cultures, urinalyses, blood cultures and differential blood counts are necessary before adequate therapy can be instituted, and immunological measures applied to control the disease.

There are, to be sure, certain classical signs of disease with which every physician is or should be acquainted, but these too are at times insufficient alone to carry out proper measures. By the combined use of physical signs seen at the bedside, plus certain few laboratory diagnostic aids, the acute medical emergency can be successfully handled.

The Laboratory in Medical Emergencies

Given a case usually constituting a medical emergency, under the common term of "coma," and note again the implications and diversity of diseased conditions that must be considered. They are: the common stroke (apoplexy) or cerebral hemorrhage; blood clot on the brain (cerebral thrombosis); diabetic coma and its converse hypoglycemia coma; uremic coma; syphilis; brain tumor; epilepsy; coma of terminal heart disease, etc. What a sad state of affairs would exist if we gave the patient in diabetic coma more sugar instead of the necessary insulin, or gave the person in hypoglycemia shock insulin instead of the much needed sugar. By the simple expediency of the urinalysis and blood sugar determination, both cases can be adequately diagnosed, treated, and restored to relative good health. Blood chemistry studies of nitrogen excretion, urinalyses and the x-ray, Wasserman, and spinal fluid examination, will aid in differentiating one condition from the other.

Blood Chemistry

Blood chemistry determinations are of particular value in the practice of internal medicine and surgery, and as such allow both the internist and surgeon to evaluate the patient as a surgical risk, thereby enabling the adoption of the best suited anesthetic agent to the surgical procedure, after due preparation of the patient with regard to mineral and carbohydrate balance, sugar storage in the liver, blood counts, bleeding and coagulation time. Surgery is no longer out of reach of the debilitated patient, and by the adequate use of biochemical studies, the one-time condemned patient can be restored to a state of operability by augmenting kidney function, increasing heart

reserve, restoring mineral and vitamin balance, and correcting blood and glandular deficiencies. Without the aid of the laboratory much of the preparation which a surgical case receives today would be lost in the quagmire of presupposition. It is just as important to have the surgical patient in mineral balance and water balance as it is to have the necessary amount of sugar stored in the liver to be used during anesthesia and convalescence.

No less an instrument than the electrocardiograph often forestalls many a gall bladder operation by detecting organic disturbances of heart rhythm, and heart muscle deficiencies that would go unrecognized by the usual methods of diagnosis. The relative acuteness, or chronicity, of an inflammatory process is again appraised by the white blood count and differential studies, before surgery is attempted, such that the surgeon is informed of the fight the natural defenses are waging against the infection. On appraisal of the oxygen carrying capacity of the blood by routine hemoglobin determinations, will often make a patient a better risk if blood transfusion is undertaken prior to surgery rather than after surgery. It is not only of scientific interest, but to the interest of the patient, to have some idea of the circulating proteins in the blood and the ratio in which these exist in the blood stream.

Biochemistry

Only within the past few years has it been a known fact that deficiencies in circulating blood proteins and in Vitamin C lead to disruption of wounds, delayed healing and poor tissue regeneration. Only through biochemical studies have the surgeons avoided unnecessary waterlogging of the tissues after operation by their vigorous attempts to support the circulation, little realizing that sodium and chlorine exist in a definite proportion in the blood plasma and are there to maintain proper osmotic relationships between the blood and its surrounding tissues. Certain types of non-mechanical upper intestinal obstruction, due to deficiencies of proteins in the blood, are rapidly corrected by the administration of one of the most potent blood proteins—namely, the matched blood of a suitable donor.

It is quite a rare sight to see a patient, almost moribund, waterlogged, sluggish and just not getting along, suddenly become bright, snappy and with appetite restored after the doctor orders meat for his patient, with the interdiction of salt. Simple as it is, these observations are all sanely and scientifically proven and without methods of precision much surgical work would come to a bitter end. The preparation of patients with Vitamin K who have a tendency to hemorrhage is striking in the cases of benign and malignant obstructive biliary disease.

The preparation of these patients for safe surgical approach constitutes a problem for the combined efforts of laboratory, internist, and surgeon. Here, through the use of Vitamin K, bile salts, and glucose, the coagulability of the blood is restored to normal, the small intestine digests fats, and the liver function is restored to a safer level. Thus, it is plain to see that surgeons of today must have graduated from the stage of barber surgeons of the middle ages, when only a skilled hand and strong assistants to restrain a patient in the dorsal recumbent position long enough for the surgeon to perform his work were necessary. Today the surgeon must combine the services of anatomist, pathologist, and, last but not least, biochemist and craftsman, who must work manually to aid nature in the physiological restoration of function to diseased organs.

Gastric Content Analysis

In diseases of the stomach and intestines, laboratory methods are very essential to a correct diagnosis. It is not necessary for every patient with gastric symptoms to have a gastric analysis made, because there are many neurotic individuals who are always complaining of various forms of gases, and the difficulty of obtaining relief by the usual domestic remedies. It would be wise to insist upon the examination of the gastric contents for a person 50 years of age or older who gives a history of loss of weight, acute onset of dyspeptic symptoms in which the conditions persists longer than three weeks. The only chance that a patient has with cancer of the stomach depends upon early recognition long before a tumor can be felt, or loss of flesh has gone to a marked degree. It is a safe rule in which a chemical analysis of the gastric contents has been made, and reveals the true absence of free hydrochloric acid and lactic acid present in appreciable amount, that malignancy is a sure diagnosis.

Cancer

There is much being written today about cancer. The clinical laboratory has much to offer in this field of tissue study. Every physician and surgeon knows of the utter hopelessness, untold misery and sometimes utter ghastliness and inevitable death resulted from the failure to excise a sore or a bit of tissue which might have been examined in the clinical laboratory at an earlier date, and its cancerous nature detected, and early treatment instituted with the x-ray, radium, electric cautery, etc.

There is no one absurd enough to believe or to

say that the clinical laboratory, with all of its instruments of precision, can ever completely replace the searching history and general physical examination of the truly earnest physician or surgeon, but in this enlightened age, no physician should be so indifferent to the interest of his patients as to allow any means for a correct diagnosis to go unused, especially one as valuable as the clinical laboratory. Certainly the item of expense and practicability must be considered always. My belief is that the patient would much rather have two dollars added to his bill and have added assurance that he has been examined, and given the benefits of every advantage science can offer, than to have a smaller bill and receive only a desultory examination.

Conclusion

In conclusion, I wish to state that the people still like the magic of human sympathy and the mysticism of personality, but I am certain that the majority also demand that the art of medicine and surgery be mixed with a little medical science. To be sure, we all want for our physicians men who can inspire confidence, and whose personality pleases, but we should also like him to feel certain of his premises and to have such confirmation of his opinion as may be derived from the use of microscopes, chemical tests, culture tubes, and the x-ray, to the desired but never attained goal in medical practice—a specific test for each disease—and a specific cure for each disease.

Surgical Catgut

The Second Supplement to the United States Pharmacopeia XI, issued in September, 1939, includes a standard specification for surgical catgut. This specification includes:

1 Technic for the determination of sterility.

2 Each strand to be preserved in an individual hermetically sealed glass container in which sterilization has been effected.

3 Minimum standards of tensile strength and methods of testing both by "straight pull" and "surgeons' knot."

4 Diameter limits and evenness of diameter throughout the length of the strand.

5 Length to be within ten per cent of the length stated on the label.

6 The old designations of ten-day, twenty-day, etc., to denote rate of absorption of chromicized catgut have been replaced by the terms "mild treatment," "medium treatment," and "prolonged treatment."

This is due to the fact that whatever the treatment the rate of absorption after any given treatment has been found to be highly variable under different conditions existing within the patients' tissues and the designations—ten days, twenty days, etc.—were therefore considered to be misleading.

Due to this same fact it has not been possible to devise any *in Vivo* test which would be reliable. But Kaissl and Meleney have proposed an *in Vitro* test with tryptic digestion which promises to be reliable under properly controlled conditions. The Advisory Board hopes to recommend the inclusion of this test as soon as a standard trypsin preparation and standard technique can be settled upon.

7 These standards become official July 1, 1940.

The hospital is the training ground of the entire medical profession. No student can qualify as a doctor unless he has had practical hospital experience. Text books alone will not help him; he must for a period be attached, like an apprentice, to a hospital, and in his examinations he will be asked questions and undergo practical tests which only that experience can answer for him.

The necessity for practical training as well as theoretical knowledge is obvious, since a sick person is a human being as well as a scientific problem. A doctor must understand how the individual patient reacts to his environment, to infections, and to other causes of disease; he is dealing with living sentient beings, not with inert materials or laboratory animals. Hence the need for hospital experience. Few general practitioners care to undertake singlehanded the management of complicated illness, and still fewer will carry out surgical operations on their patients; such medical problems demand the cooperation of general practitioner and specialist. But the onus of determining when a second opinion and specialist help are essential lies with the general practitioner, and only his training in hospital can give him the experience necessary for a proper and early decision.

Dawson of Penn

The oldest known drug prescription, says the New York State *Medical Journal,* is written on a stone tablet of 3700 B. C., bearing directions for making an inhalant for a head cold.

The Sterilization of Silk Sutures in Oil

WILLIAM E. QUIGLEY and MAURICE LAZARUS

IT IS well known by bacteriologists that bacteria in the dry state are much more resistant to heat than in the wet state. It is for this reason that although bacterial spores are killed in the saturated atmosphere of the autoclave at about 125° C. (257° F.) within twenty minutes, dry spores are not killed at this temperature even when exposed for a much longer time in a dry air oven. Spores embedded in oil or petroleum jelly are protected from moisture and so are not killed by the usual process of autoclaving. Mineral oil, petroleum, and some animal and vegetable oils may be subjected to higher temperatures without injury and should be so sterilized.

In the sterilization of sutures there has to be considered also the effect of the process on the tensile strength of the suture. The sutures used for these experiments were of black silk. It had been found that in the ordinary process of autoclaving their tensile strength was weakened. Furthermore, for other reasons it was desired to sterilize them immersed in oil. The following experiments were designed to determine under what conditions the suture material impregnated with spores of tetanus bacilli and immersed in the oil might be sterilized.

The Apparatus

The apparatus used for sterilizing the material in oil was a pressure cooker (size 16 quarts) which is essentially a small autoclave made of cast aluminum and heated over a gas burner. Fitted into the lid of the pressure cooker was a thermometer with a long stem so that the bulb of mercury extended nearly to the bottom of the vessel. Into the pressure cooker was placed 5000 cc. of mineral oil which filled the vessel to a depth of about three inches. When the oil in the cooker had been heated up to about 200° F. (94° C.) the test tube containing the suspension of tetanus spores and suture material in peanut oil was stood upright in the mineral oil. The lid, with the air vent closed, was placed upon the cooker, the temperature raised and held at 300° F. (149° C.) to 308° F. (153° C.) for thirty minutes. The closing of the pressure cooker probably served no other purpose than to retain the heat and make it more uniform throughout. The mineral oil was used repeatedly and seemed to improve with use since some of the volatile portion was driven off with the first use and thereafter it was easier to maintain uniform temperatures.

The Authors

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The Experiments and Their Results

The suture material was reduced to matting by grinding in a mortar. The growth from blood agar slant of Clostridium tetani containing many mature spores was suspended in 10 cc. of peanut oil and the ground suture material well mixed with it. For each experiment there were inoculated one guinea pig and one cooked meat culture tube with the heated material and, as controls, one guinea pig and one cooked meat culture tube with the unheated material. The guinea pigs were injected into the right thigh with a mixture of 0.5 cc. of the suture material suspension and 0.5 cc. of dilute lactic acid, the acid serving to produce an initial necrosis favorable for the growth of tetanus bacilli. The cooked meat medium was under petrolatum seal to provide anaërobic conditions.

Ten experiments using a total of 20 guinea pigs and 20 tubes of cooked meat were carried out as described. All of the guinea pigs inoculated with unheated material died within 3 to 6 days with typical symptoms of tetanus and the corresponding cooked meat culture showed growth of tetanus bacilli in 3 to 4 days. The cooked meat culture tubes inoculated with heated material remained sterile. None of the guinea pigs inoculated with heated material developed tetanus but the first five inoculated developed gangrene of the inoculated leg after some days and died after two weeks. This was found to be due to the con-

centration of the lactic acid injected (10 per cent) as determined by the injection of three other guinea pigs with 10 per cent lactic acid in sterile peanut oil. For the remaining five experiments the concentration of the lactic acid was reduced to 5 per cent and no necrosis developed. In all the guinea pigs injected with unheated materials death from tetanus occurred before necrosis was observed.

By similar experiments a suspension of tetanus spores and suture material in peanut oil heated at 250 to 256°F. (121 to 125° C.) for 30 minutes was found not to be sterile. A similar suspension heated at 260 to 266° F. (127 to 130° C.) was sterilized. It would appear, therefore, that there existed a considerable margin of safety in employing a temperature of 300 to 308° F. (149 to 153° C.) for 30 minutes.

Tensile Strength Not Materially Affected

The tensile strength of the sutures was found not to be materially affected at temperatures below 310° F. but was found to be progressively weakened as higher temperatures were employed.

In the above experiments with matted suture material peanut oil was employed because it was not desired to inject 0.5 cc. of non-absorbable mineral oil into the guinea pigs. In the sterilization of intact silk sutures it is proposed that the reels should be immersed directly in the mineral oil most of which is allowed to drain off before the sutures are used.

Old-Age Pensioner May Get Medical, Hospital Care Is Clarified in Ohio

Responsibility for the payment of the hospital costs and costs of medical care of old-age pensioners who are hospitalized was clarified by Attorney-General Thomas J. Herbert in *Opinion No.* 1633, issued December 30, 1939, in answer to a request from the prosecuting attorney of Marion County.

Syllabus of the opinion follows:

1 It is the duty of the Division of Aid for the Aged, when the recipient of aid is a patient in any private charitable, fraternal or benevolent home or institution, other than a state institution, to pay within the limit of *Section* 1359-3, *General Code,* the reasonable cost of such maintenance, including medical services and such payment shall be made to the governing body of such institution.

2 When the total cost of such maintenance exceeds thirty dollars per month, then the amount in excess of thirty dollars must be borne, in so far as medical expenses are concerned by the local relief area under *Section* 3391-1 *to* 3391-13, inclusive, *General Code,* and the hospitalization costs must be borne by the property city or township authorities, depending upon the logal settlement of the person, under the poor relief statutes, *Section* 3476 *to* 3496, inclusive, *General Code.*

3 A pension may not be cancelled without cause, and if a cancellation does occur, a recipient whose aid has been cancelled may appeal from the action of the local subdivision to the Division of Aid for the Aged, and upon the filing of an appeal the recipient must be given a prompt and fair hearing.

Mary Ellen McIntyre

Mary Ellen McIntyre, who has been administrator of the Meriden Hospital, Meriden, Connecticut, for the past twelve years, died on March 4.

Miss McIntyre was born in Inglewood, Ontario, Canada, and received her preliminary education in Toronto, following which she entered the school of nursing of the Albany Medical College, Albany, New York. After her graduation she became administrator of the Hillcrest Hospital, Pittsfield, Massachusetts, and then director of the school of nursing at United Hospital, Portchester, New York. Miss McIntyre resigned from the United Hospital to become director of the school of nursing of St. Luke's Hospital, Cleveland, Ohio, and later became administrator of the New York Infirmary for Women and Children.

Miss McIntyre was a Fellow of the American College of Hospital Administrators and one of the oldest members of the American Hospital Association and the Connecticut State Hospital Association.

James Howell Rucks

James Howell Rucks, for the last fourteen years administrator of Wesley Hospital, Oklahoma City, Oklahoma, died on April 22 from a cerebral hemorrhage at the age of sixty-eight.

Mr. Rucks was an active civic worker. He was one of the organizers and a past-president of the Oklahoma State Hospital Association.

As administrator of Wesley Hospital, Mr. Rucks developed that institution to more than twice its original capacity, and he established its reputation for the excellent quality of its professional care and of its hospital service.

Social Aspects of Hospital Service Plans

MICHAEL A. KELLY

The Author

● Michael A. Kelly is Associate Director of the Cleveland Hospital Service Association, Cleveland, Ohio.

MANY people wonder and continue to be amazed at the rapid growth of the nonprofit hospital service plans in the United States. They find it hard to believe that, for example, close to one-half million people in Ohio are already subscribing to such plans, and that throughout the United States, close to five million people now provide for their hospital care in this manner.

If I were to be asked for an explanation of this rapid growth, it would be that such a service in connection with hospitals was long overdue in this country. Practically every other field outside of health, had made direct provision for its financing in some sort of small weekly or monthly payments. Among those people in the middle and lower income brackets, it had become the accepted form of purchase and it had enabled them to buy many necessities, comforts, and luxuries that had been denied them in the past.

While the American family was continuing to surround itself with many additions to comfortable living during the lush twenties of this century, hospital service stood almost alone as a field in which steps were not taken to make the financing of service possible. It was only natural that as soon as such a plan for financing complete hospital care was made available, millions would subscribe in a very short period of time. In the past, many a family budget was completely wrecked by an unexpected hospital stay for some member of the family. Here at last, was a service designed by the hospitals themselves that would completely remove the worry over future hospital bills.

Hospitals within communities grouped to form what we now know to be nonprofit hospital service plans. Since hospital care in this country had been traditionally rendered on a nonprofit basis, it was certain that the public would demand and the hospitals would insist, that these plans be operated on a not-for-profit basis. After the corporation was formed and a plan director selected, an office staff and a staff to contact the public were employed on a straight salary basis involving the payment of no commissions for the sale of hospital service contracts. The public were informed that they were being offered a contract for service which was a direct obligation of the participating hospitals, and in Ohio, legislation dating back many years was already on the statute books which made such a contract for service exempt from the insurance laws of the state, providing such contracts were sold only to residents of the county in which the contracting hospitals were located. Almost from the very beginning, volume enrollment resulted, and as far back as 1934, the Cleveland Plan was enrolling a thousand new subscribers each month. Today that number has increased to over ten thousand new subscribers each month.

Comparing Hospital Service Plan Benefits with Commercial Insurance

Prior to the formation of these nonprofit hospital plans, the commercial insurance field had been selling, and is continuing to sell, a health and accident policy, which made provision for reimbursement to the policy holders of a certain cash sum for every day the policy holder was hospitalized, but with certain maximum limitations in dollars and length of hospital stay. This phase of commercial insurance never made any great strides and practically all activity was confined to the white-collar class. For about eight out of every ten people, this type of insurance was beyond their ability to pay and furthermore, none of these commercial policies agreed, nor could they agree, to provide full payment for a hospital bill for any stated period of time. The introduction of the nonprofit hospital service plan sponsored by the hospitals themselves, was able to provide this very need; assurance of full hospital

Presented at the Annual Ohio Hospital Association meeting.

care and at a price low enough for any employed man and his family to meet. And so the cavalcade started in this country of what I have previously mentioned: millions of Americans anxiously seeking enrollment in these nonprofit plans.

Some of the smaller commercial insurance companies recognizing this phenomenal success, decided to take their old accident and health policies and by eliminating certain benefits, reduce and restrict their payments to cash sums to policy holders only in the event they were hospitalized. To such a policy they gave the name "Hospitalization," which to us in the nonprofit hospital service field, is a misnomer. Briefly, what they do provide is limited cash sums to which they are obligated to the insured only for each day they are hospitalized, with certain restrictions as to length of stay. They do not provide hospitalization because they do not have it for sale. Only hospitals themselves, through their own nonprofit hospital service plans, can sell hospital service because only they operate the physical properties necessary to provide such service.

Cash Indemnity for Hospitalization vs. Hospital Care Without Monetary Limitation

The next step we come to is the cost to the public of commercial insurance policies offering cash indemnity to the policy holder when hospitalized, as against the cost of nonprofit hospital service plan contracts offering hospital care without monetary limitation. In Cleveland, for example, our plan provides care for as low as sixty cents per month for the individual, or one dollar and fifty cents per month for an entire family with all children from one to nineteen years of age included. We provide twenty-one days of hospital care to each member of the family every year. Included in our service are bed and meals, general floor nursing, use of the x-ray department, use of the operating room, anesthesia and administration of anesthesia, routine laboratory service, all ordinary drugs and dressings and, after twelve months of enrollment, we include full maternity service including use of the delivery room.

I know of no commercial insurance policy that offers even limited cash payment towards a hospital bill for a charge as low as ours. But the rate to the public is only one small part of the picture. Let us look further into just what happens to the dollar in commercial insurance and what happens to the dollar in nonprofit, hospital-sponsored service plans.

One commercial company attempting to sell a policy of this type in Ohio insists, mind you, insists that its overhead expense is not greater than thirty-eight per cent. Total administrative expense for the Cleveland nonprofit plan is now at eight per cent of earned income. Even if commercial companies sold their policies as low in rate as we sell our contracts, they would only have sixty-two cents of every earned dollar available for claims and required reserves; whereas, our nonprofit plan has ninety-two cents of every dollar. In other words, we have a sum fifty per cent greater available for direct benefits to subscribers and in reserve for epidemics. Therefore, it is only a matter of simple arithmetic that we can furnish a greater amount of service for the dollar than they can pay out in cash indemnity to their policy holders. In order to render a complete hospital service based on the needs of our community, at least eighty per cent of present rates are needed for current hospital care alone. With an overhead of thirty-eight per cent, a commercial company most assuredly cannot furnish a similar service for comparable rates.

In the years we have been operating in Cleveland, we have seen many such small commercial companies start and stop in the sale of what they like to call "Hospitalization." Even the reputable life insurance companies that in some cases offer a hospitalization rider to their group life policies, seem to have curtailed their sales activities of this sort in our area, and as for the small, one-string companies that claim they furnish hospital care, we never hear of them in our contact with the public at places of employment.

Hospital Service Plans Do Not Conflict with Reputable Health and Accident Insurance

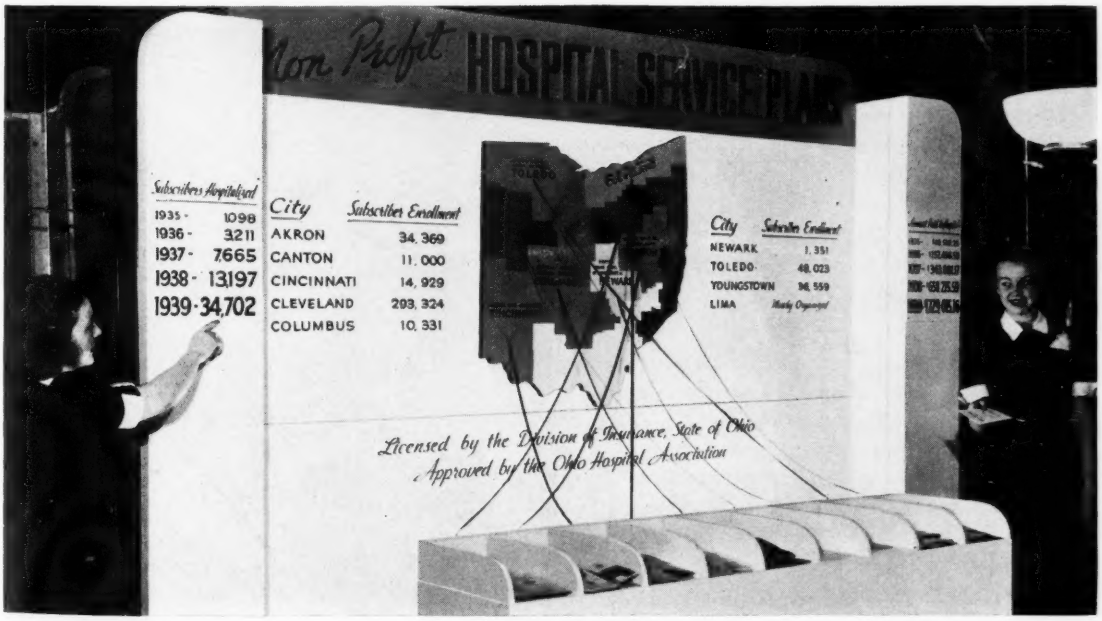
Reputable health and accident companies in no way conflict with nonprofit hospital service plans. We never advise a prospective subscriber to drop such coverage when enrolling in our service. If he can afford to carry such a policy in addition to a contract for hospital care, he should by all means do so. However, you must keep in mind that not many workers can afford to buy such policies; whereas, very few cannot afford to pay one dollar and fifty cents per month for full hospital care for their entire family. The employees of practically every insurance company in the Cleveland area are enrolled in our nonprofit plan and on the other hand, many people employed in the hospital field have purchased health and accident policies from reputable companies and would not think of being without them. What better evidence need we have that these two in no way conflict. Our criticism is only of those organizations that claim they are selling "Hospitalization" when in fact, what they are really offering

is a most limited type of health and accident policy at a rate to the public at which full hospital care is available. They are the people who, hungry for dollar profits, will stop at nothing to retard the further development of the nonprofit plans. They fought us in our victorious efforts for new legislation that now brings our plans under the supervision of the Division of Insurance of the State of Ohio and removes our former county limitations. Our success in this work was overwhelming, with an almost unanimous vote in the House and the Senate. They have pestered our plans and others with petty nuisance suits which, needless to say, cost money to defend, no matter how ridiculous they may be.

Hospital Cooperation with Service Plans

As hospital administrators, I know you must be asking yourself just how you can best cooperate and best protect your own interests in this matter and in this connection, may I make this suggestion. If your institution is a participating hospital or a cooperating hospital of one of the nonprofit service plans, remember that when a subscriber to such a plan enters your hospital, he carries a contract for care to which you are a direct part. You have agreed to furnish the care or accept the case as a direct part of his agreement. You are not an outside party to this contract, but in the case of participating hospitals, appear as the party of the first part. You should receive the subscriber as one who has already made a financial arrangement with you for his hospital care. If the patient holds an insurance policy to which you are in no way a part, he should be received exactly the same as any other patient and should be made to conform with your established credit arrangements for admission of private patients.

It is the general practice of insurance companies to reimburse the insured upon the filing of what the company considers a meritorious claim, and their obligation is only to their policy holder. The assignment of such payments due the patient in no way binds the company to allow the claim and such assignment by the patient to the hospital can be no guarantee to the hospital that the bill will be paid. Since the agreement is purely between the company and the insured, it is only sound practice that the patient make his own arrangements for payment to the hospital. If special consideration is given to a patient who holds a commercial insurance policy, the public is led to believe that an agreement between the hospital and the insurance company exists. I realize that you wish to create no such impressions, and in this connection, I want to say that in practice, practically all hospitals have stood strongly behind their own nonprofit plans. They rightfully share in the success of this great community service and I am sure that the hospitals in the Cleveland area have risen to an even higher point in the appreciation of the community for having developed a plan for hospital care that most certainly ranks as the outstanding social development of our times. Nonprofit hospital service plans are not selling insurance—they are meeting an important social need that is destined to reach out to every employed man and his family—without thought of dollar profits and in a way the American people are clearly indicating they wish to make provision for their hospital care.



Hospital Service Plan News

Prepared by the Commission on Hospital Service and the Council on Hospital Service Plans

HOSPITAL Service Corporation of Western New York, Buffalo, recently mailed a series of letters to industrial leaders of their area. These letters were drafted with the attempt to explain the fundamental purpose and methods of nonprofit hospital service plans. The following excerpts illustrate points of view which the Hospital Service Corporation wished to place befor the public:

". . . The American concept of life has in the past always been one of independence and self-determination. It was in keeping with that concept that the voluntary nonprofit hospital plans were organized to provide an easy means for the average individual to budget for unexpected sickness costs. As early as 1935 compulsory health insurance legislation was introduced, providing for its inclusion in the social security laws passed in that year. It was with difficulty excluded from the act at that time. . . .

"With the need for a health budget program clearly demonstrated and with public spirit generally in favor of some form of health insurance, we cannot condemn government policies unless we have an efficient and effective alternative which is actually and satisfactorily operating on a large scale. If and when compulsory health insurance comes, both you and your employees will be heavily taxed (there are sponsors of the movement in both political parties). Whoever pays the major portion of the tax, the Blue Cross contends that those business men and industrialists who fail to give full support to voluntary plans will be largely responsible for the institution of an involuntary federal or state plan based on a system of compulsory taxation. . . .

"Frankly, the biggest problem the Blue Cross has had to solve is the obtaining of the full cooperation of the employer in this matter of payroll deductions. But, this provision in our set-up is fundamental. It makes possible more ample benefits to the subscriber. It assures the expenditure of the largest possible percentage of the Blue Cross income dollar for hospitalization. It is the reason the Blue Cross here has been able to maintain one of the lowest family subscription rates in the country. It is why we have twice increased benefits. It is why we have the most representative cross-section of our community on the Blue Cross roster. . . ."

* * *

Arrangements have recently been completed to have the approved hospital service plans in California also join with the California Physicians Service, sponsored by the California Medical Society, in the enrollment and service of subscribers. A joint acquisition committee has been formed with representatives from the California Physicians Service, the Insurance Association of Approved Hospitals, San Francisco and Oakland, and Associated Hospital Service of Southern California, Los Angeles.

J. Philo Nelson is in charge of enrollment for the three organizations as well as general manager for Insurance Association of Approved Hospitals. His headquarters are at San Francisco. William G. Ebersole is in charge of acquisition and general activities for Southern California with headquarters in Los Angeles. At the present time California Physicians Service has an enrollment of approximately 12,000 enrolled subscribers, many of whom are also participants in the respective hospital service plans.

* * *

"Group Hospital Service Spells New Freedom for Lower Income Groups" read the headlines in the January 19, 1940, issue of the *Saint Louis Catholic.* The following excerpts are taken from the article: ". . . The regimentation inevitable under the but yesterday proposed plans for state medicine or some form of compulsory health insurance, pointing to a totalitarian form of government, is still the hope of formidable advocates.

"These plans, however, have dwindled for the time being to proposals for construction by the Federal government of hospitals in communities not adequately provided for.

"The people have won a battle—but the war to forever end the threat and menace of free choice of the family as to physician and institution of

treatment during illness will be won only when all those in the low income groups have been provided with adequate protection. . . .

"By what means have over four million individuals and their families in the lower income groups attained this economic protection in times of serious illness or injury? It has come through the Nonprofit Hospital Service Groups. . . .

"The corporative membership of Group Hospital Service, Inc., is composed of . . . representatives from each participating hospital . . . physicians to a number equal to the whole of the hospital representatives, with individuals to represent the public chosen by the medical and hospital representatives. The trustees are chosen by the corporate membership. . . .

"The subscribing member is provided with a direct contractural obligation by the participating member hospital. . . .

"In this plan we have the first line of defense against a form of encroachment on the rights of the individual, and the field of . . . trained physician and the . . . hospital. . . ."

Legislation Relating to Hospital Service Plans

An act to amend and re-enact the law relating to the incorporation and regulation of nonprofit hospital service corporations in the state of Kentucky was introduced at the regular 1940 session of the House of Representatives. This Act provides that all proposed articles of incorporation be approved both by the State Commissioner of Insurance and the State Commissioner of Health before being filed in the office of the Secretary of State or recorded in the County Clerk's office, and that the State Board of Health be authorized to make rules and regulations for the registration and approval of hospitals.

* * *

Extension of state health care is urged by representatives of the New York Medical Society and the state legislature. Both Assemblyman Lee B. Maller and Dr. James F. Rooney agreed that a system of voluntary medical insurance similar to the "hospitalization" plan would be helpful to those in the middle classes who cannot afford satisfactory medical treatment.

Urging "combined cooperative efforts of the public, the physician, and the government" as "essential to insure the development of a sound, long-range health program," Assemblyman Maller, himself a superintendent of a hospital, pointed out why the state is taking increasing responsibility for the support of public health and medical care services:

"First, the scientific advances in sanitation and medicine have increased the cost to the public. Then, many studies by both government and private agencies have shown that there are large numbers of our people who find themselves unable to meet the cost of needed care."

Expansions and Mergers

The Hospital Service Association of Pittsburgh has recently opened a branch office in Erie, Pennsylvania. Robert V. Fortune has been placed in charge of this office, which is located at 1307 Erie Trust Building. The addition of the two Erie hospitals increases the number of participating institutions to 72.

* * *

Associated Hospital Service of Massachusetts, Boston, has outgrown its offices at 21 Milk Street, and will move to the Western Union Building, 230 Congress street, about May 1. The new Blue Cross headquarters will occupy the entire fifth floor of the building.

* * *

According to Clement W. Hunt, executive director of the Capital Hospital Service of Harrisburg, Pennsylvania, a branch office will soon be opened at 544 Court Street, Reading, Pennsylvania.

* * *

The Hospital Service Plan of Danbury, Connecticut, will be merged with The Hospital Service Plan, Inc., of Norwalk, Connecticut, as of May 1. The Norwalk plan is assuming the subscriber contracts of the Danbury Plan, which, in turn, is paying the Norwalk Plan a sum in cash representing the unearned premiums on that date. The earned surplus of the Danbury Plan will be retained by their directors as trustees and will be used for the payment of all claims originating prior to May 1. They will also liquidate any other liabilities which may be outstanding. This merger will bring the number of subscribers to the Norwalk Plan to about 30,000.

* * *

The Vol. 15, No. 7 *Bulletin* of the Community Chests and Councils dated March, 1940, contains an outline for self-analysis of local programs for free medical care, prepared by Dr. Gertrude Sturges, consultant on medical care for the American Public Welfare Association. A full report of a nation-wide study on the subject (Report of the Committee on Medical Care, 1938) may be obtained from the APWA, Chicago, Illinois.

* * *

A general report entitled "Business Census of Hospitals, 1935," has been published by the United States Public Health Service as Supplement No. 154 to the Public Health Reports. This Report is written by Elliott H. Pennell, Joseph W. Mountin and Kay Pearson and can be obtained

from the Superintendent of Documents, Washington, D. C., for 10 cents. This pamphlet includes 37 tables and 10 maps and diagrams.

* * *

The *Council Digest* published by The Peoria Council of Social Agencies reports the following in their Vol. 4, No. 2, issue of March, 1940: "The month of December saw 11,674 subscribers and dependents enrolled in the Central Illinois Hospital Service Association, it is learned from Paul F. Bourscheidt, executive director of the organization.

"Fifteen hospitals in Galesburg, Macomb, Kewanee, La Salle, Ottawa, Pekin, Peoria and Quincy comprise the Association and 75 per cent of the growing enrollment, upon analysis, was found to consist of individuals earning less than $2,000 annually.

"Acceptance of the Association's program as a sound method of planning for future emergencies is rapidly receiving general recognition, and applications continue to increase."

Personnel

Harold E. Roush, formerly acting director of Hospital Service Association of Summit County, Akron, Ohio, has been appointed executive director to succeed the late Thomas B. Wood.

* * *

Peter E. Klein, formerly district director of the Minnesota Hospital Service Association at Duluth, has been appointed executive director of the North Dakota Hospital Service Association, First National Bank Building, Fargo, North Dakota, a state-wide plan.

* * *

The latest additions to the staff of Hospital Service, Inc., of Iowa are Hamilton Clarke, formerly with Associated Hospital Service of New York, and Charles DeWinter, formerly with the Iowa Unemployment Commission.

* * *

Victor H. Breitenbach has been appointed field representative of Associated Hospital Service, Inc. (Milwaukee) of the Wausau, Wisconsin, area.

News of the Plans

In observance of the enrollment of the 200,000th subscriber by the Hospital Service Association of Pittsburgh, the Association has prepared an attractive descriptive brochure which graphically depicts the progress of the hospital-sponsored plan.

Features of the brochure are charts showing the increase in membership during the more than two years the service has been in operation, the proportionate increase in the number of members hospitalized at various dates since the plan was launched, and the savings to subscribers at different periods in the service.

An entire page is devoted to reproduction of the letter-heads of prominent educational, commercial, civic and industrial organizations which are represented on the membership rolls of the Hospital Service Association of Pittsburgh.

* * *

Associated Hospital Service of Capital District, Albany, New York, holds a new record. According to a report received from E. R. Evans, executive director, a subscriber to the plan gave birth to triplets in March, 1940.

* * *

L. R. Wheeler, executive secretary of Associated Hospital Service, Inc. of Milwaukee, Wisconsin, spoke at a public forum in the Milwaukee Vocational School Auditorium on March 25, 1940, on the subject "Nonprofit Hospital Service Plans." Another speaker, Joseph Smith of the Milwaukee office of the Aetna Insurance Company, spoke on the subject, "Hospital Insurance."

* * *

Time Magazine of April 8 carried an article on medical care for Negroes. The following are excerpts regarding the Flint-Goodridge Plan, Mr. A. W. Dent, superintendent, and its relation to Negro health: ". . . Flint-Goodridge . . . boasts the cheapest, most complete hospital insurance plan in the United States. Cost: one cent a day. If he can convince his doctors, Mr. Dent will soon start a two-cent-a-day plan to provide complete medical care as well. . . ."

* * *

According to the April, 1940, *Review* of the Associated Hospital Service of Maine, there are now approximately 16,000 persons and 25 hospitals throughout Maine participating as members of the nonprofit plan.

* * *

R. N. Cunningham, Jr., promotional director of Plan for Hospital Care, Chicago, spoke at a dinner meeting of 140 industrial group leaders of the Northern Illinois Hospital Service Plan, Rockford, Illinois, on April 4, 1940.

* * *

The Central Labor Council has endorsed the Hospital Care Corporation of Cincinnati, according to a report issued by Otto Zoecklein, secretary of the Council.

The General Executive Board of the National Electrical Radio and Machine Workers of America (CIO) passed a resolution at their meeting in March endorsing the nonprofit blue cross plans approved by the American Hospital Association.

* * *

Associated Hospital Service, Inc. of Milwaukee, Wisconsin, has received approval by the local office of the International Ladies' Garment Workers of America and is now enrolling the membership of this union through their places of employment.

The March, 1940, issue of the Consumers Union Reports carried the first of a series of articles on the general subject "Voluntary Insurance." It is particularly significant because it reverses a general point of view expressed sometime ago with respect to nonprofit hospital service plans and definitely approved the principle of the service contract as opposed to the medical expense indemnity in health programs based upon the insurance principle.

New Participating Hospitals

St. Mary's Hospital and Wausau Memorial Hospital have recently become participating-members of Associated Hospital Service, Inc. of Milwaukee.

* * *

St. Ansgar Hospital of Moorhead, Minnesota, has recently been added to the list of participating hospitals of the Minnesota Hospital Service Association.

* * *

Eight new member hospitals have been admitted to Associated Hospital Service of Massachusetts. These are, Eaton Hospital, Brockton; Ocean View Hospital,* Swampscott; Groton Hospital, Groton; Shaw Hospital, Lowell; Whitinsville Hospital, Whitinsville; Emerson Hospital, Jamaica Plain; Glynn Hospital,* Dorchester; Revere General Hospital,* Revere.

Correction

In the April number of the Hospital Service Bulletin the list of Committee Members included the names of John A. McNamara, E. G. Smith, and Michael A. Kelly, of Cleveland. These names were included in error and should not have appeared in this list.

Meetings

The Fifth Annual Assembly of the Southeastern Hospital Conference was held at Edgewater Park, Mississippi, on March 28, 29, and 30. One general assembly was devoted exclusively to reports on the progress of hospital service plans in the southeastern states. The following persons reported on the progress in their respective states: Ed. S. Moore, Alabama; J. H. Holcombe, Florida; C. J. Anderson, Georgia; Edward Groner, Louisiana; A. Street, M.D., Mississippi; and George W. Eutsler, Tennessee. C. Rufus Rorem, together with Graham L. Davis of the Kellogg Foundation, led a round table discussion after the papers were presented.

* * *

Group Hospital Service of Kansas City, Earl R. Sweet, executive director, was host to a number of hospital service plan representatives who participated in the meetings of the Mid-West Hospital Association which were held in Kansas City on April 11 and 12. The following representatives of hospital service plans took part in the panel discussion on Nonprofit Hospital Service Plans: Msgr. John R. Mulroy, Colorado; Walter R. McBee, Oklahoma; William S. McNary, Colorado; Earl R. Sweet, Kansas City; Ray F. McCarthy, St. Louis. Maurice J. Norby, director of the Research Program of the Council on Hospital Service Plans, also took part, as well as the following representatives of hospitals: Rev. O. J. Carder, superintendent, Missouri Methodist Hospital, St. Joseph; Mary J. Keith, superintendent, St. Louis Maternity Hospital, St. Louis; and Dr. Raymond T. Smith, President, Arkansas Hospital Association.

* * *

The program of the First Richmond Institute for Hospital Employees, held in February and March (five separate sessions) included one session on "Hospital Service Plans—Group Hospitalization." Dr. Lewis E. Jarrett, member of the Council on Hospital Service Plans, presided. Dr. Joseph F. Geisinger, director of Richmond Hospital Service Association, read a paper on "The Benefits of Group Hospitalization to Patients," and M. Haskins Coleman, Jr., executive director of the Richmond Hospital Service Association, led a round table discussion on Group Hospitalization.

* * *

The Associated Hospital Service of Philadelphia at its annual meeting re-elected all of its officers for the year 1940. New directors include Alfred Mayer and May Middleton, administrators of Jewish and Methodist hospitals, respectively; A. L. Fitzpatrick, trustee of Fitzgerald-Mercy Hospital; Drs. Richard Larer, president of the Philadelphia County Homeopathic Society, Edward Bortz, president of the Philadelphia County Medical Society, and Robert Devereux, representative of medical groups outside Philadelphia.

* * *

The Ohio Hospital Association held its annual meetings at Columbus on April 2, 3, and 4. One section was devoted to nonprofit hospital service plans, and the following representatives of approved plans participated: John A. McNamara and Michael A. Kelly of Cleveland; John R. Mannix of Detroit; and Robert E. Mills of Youngstown, Ohio.

* * *

At the third annual meeting of Central Illinois Hospital Service Association, the following officers were re-elected: O. P. Westervelt, Peoria, president; Clyde Hunter, Quincy, vice-president; Edward A. Powers, Peoria, James V. Richards, Pekin, and Charles D. Terry, Kewanee, vice presidents; John H. Bontjes, Peoria, secretary-treasurer.

Price Trends in Hospital Commodities

McGill Commodity Service, Inc., Auburndale, Massachusetts

Sponsored by the Committee on Purchasing of the Council on Administrative Practice

AFTER seven months of jockeying, World War No. 2, as predicted, has become more intensified. We say "World War" because, fundamentally, every nation is economically involved. Viewpoints and opinions concerning forthcoming events and the ultimate outcome are abundant and cheap. The truth of the matter is that no one knows the answer to the European problems, and we can only stress the futility of attempting to forecast war developments during the spring and summer months. We have often stated that it is the unexpected which takes place, and this will continue to be the case. The chain of events that have made history, involving the seizure by Germany of Austria, Czechoslovakia, Poland, and now Denmark and Norway, and Russian conquest of Finland clearly indicates first that there is no security for the smaller and weaker nations, and second, that each violation broadens the foundation which supports a prolonged war. German occupation of Scandinavia will inevitably cause serious economic repercussions. Keep in mind that World War No. 2, due to new inventions, mechanized military equipment, and impregnable fortifications, will likely be confined principally to the air and the seas. Furthermore, as stated in our reports last fall, the issue may be settled entirely on Scandinavian soil.

Wars which have occurred at frequent periods since the beginning of civilization always create certain conditions that in turn profoundly affect economic trends. Regardless of the theory of economic control, we know that war results in, first, an increase in producing costs; second, a sharp elevation in transportation costs; third, curtailed production as output is diverted from normal constructive to destructive channels, and fourth, war makes waste, impairs purchasing power and credit, imposes burdensome taxation, and ultimately introduces inflationary characteristics. In this respect World War No. 2 is not a bit different from the previous struggles which are now so much history.

We are concerned primarily with the effect of rapidly changing conditions throughout the world upon commodity prices. This much we know: A prolonged war is paving the foundation upon which will be erected a materially higher commodity price level. Due consideration must also be given to the fact that statistically and economically domestic conditions are vastly different than was the case four and five months ago. It makes considerable difference whether production, consumption, inventories, the stock market, new orders, commodity prices, etc., are on a high or low plane. That business activity has compensated for the short-lived spree of late 1939 appears to be a fact rather than an opinion. For example, the Federal Reserve Index of Industrial production in March was down to 105 as compared with 128 last December. In a word, production is now only 2 per cent above the level in effect last August.

The inventory situation is neither critical nor top-heavy. It stands to reason that more than four months of conservative buying have enabled producers to utilize a substantial portion of the large quantities of materials purchased during the hectic and chaotic days of September and October, 1939. Now that practically every phase of the economic structure has settled back to levels more comparable with those in effect prior to the outbreak of warfare, it is only reasonable to expect that industrial activity, as well as prices, will become more sensitive to intensified warfare abroad.

Fundamentally, commodity prices are only equal to the deflated basis that existed a quarter of a century ago in 1913 and 1914. Our point is simply this: There is no room for pronounced or prolonged weakness. There is ample room for extensive price strength, particularly under the pressure of warfare which as yet has not begun to exhaust its effect upon business activity or commodity prices. Nothing new has been noted that warrants any change in the prediction that a turning point in the business trend will occur during

the current quarter. Furthermore, due allowance must also be made for the excessive credit resources in this country which are holding on the highest level ever known, exceeding 25 billion dollars. Not only will this unparalleled credit act as a cushion under the price structure, but in the course of time will prove a powerful force in creating higher prices.

All Commodities

Since the first of the year the underlying trend of commodity prices has moved steadily downward in alignment with the pronounced retrenchment in industrial activity. Last October commodity prices stood 17 per cent above the level in effect in August. Today prices are only 11 per cent above the August low and barely 4 per cent above year-earlier figures. However, there are signs that the period of price weakness has run its course, as immediately following intensified warfare, prices again bounded upward. In addition to expanding demand on the part of consumers of raw materials, there is also a new wave of speculative activity. It is extremely important to keep in mind that as matters now stand there are absolutely no inflationary characteristics in the commodity price structure.

Drugs and Chemicals

The price trend moved upward during the past month and new peaks are indicated. However, the most important development was noted in price weakness for quicksilver. Despite the uncertainty that surrounds the outlook for quicksilver imports, the fact remains that abnormally high prices have abruptly stimulated domestic output and there is every assurance of adequate supplies.

Paper Products

Uncertainties created by a diminishing rate of industrial activity since the turn of the year, conservative demand, increasing stocks, intensified competition, and the fear of price cutting are more or less eclipsed by startling events abroad involving German invasion of Scandinavia. Last year receipts of pulp from Scandinavian countries amounted to 1,299,769 tons. With this source of supply abruptly cut off the burden of furnishing adequate supplies is placed squarely on the shoulders of Canada and the United States. However, until economic betterment is an actuality rather than a prospect, the price structure of finished paper will be somewhat under pressure.

Cotton Goods

The intensification of open hostilities in Europe engendered by the invasion of Norway and Denmark by Germany had a direct effect upon cotton textile markets. Print cloth sales on April 9 were estimated at 25,000,000 yards, and prices on broadcloth, twills, sheetings, osnaburgs, and ducks were advanced from ⅛ to ¼ cent a yard on some of the active grades. Cotton yarn prices also strengthened as demand increased. The point simply is that consumers have not been buying in volume for a period of many months. Prices had declined to attractive levels, and the outbreak of open warfare was merely the spark that set off the buying wave.

Surgical Dressings

Quotations have held on a relatively stable course, but prior to the recent revival in interest in cotton goods and surgical dressings, there was a definite prospect of price weakness. The raw cotton market is in a vulnerable position now that exports are diminishing, following the elimination of the export subsidy.

Fuels

No basic change has taken place in the bituminous market, and the next important event on the schedule is the announcement of minimum prices for the Eastern consuming area. Due to seasonal characteristics, the price structure is somewhat under pressure. In fuel oil, the supply-

McGill Monthly Price Index for *HOSPITALS*
1926—100

	Apr. 1932	*Apr.* 1933	*Apr.* 1934	*Apr.* 1935	*Apr.* 1936	*Apr.* 1937	*Apr.* 1938	*Apr.* 1939	*Jan.* 1940	*Mar.* 1940	*Apr.* 1940
ALL COMMODITIES	49.9	47.3	62.7	73.1	73.3	87.4	71.5	67.4	73.5	70.6	70.1
Drugs and Chemicals	77.4	70.8	75.1	72.6	71.1	69.3	67.8	70.3	78.0	81.0	81.2
Paper Products	79.5	69.5	84.7	81.2	80.5	95.8	92.4	90.5	89.6	92.4	92.4
Cotton Goods	44.1	45.1	86.3	83.3	72.9	103.2	69.0	71.3	85.9	78.3	76.0
Surgical Dressings	64.6	65.1	84.2	81.6	76.7	85.6	70.4	66.6	73.4	74.3	74.3
Fuels	51.3	49.3	78.6	74.3	71.1	90.4	85.5	81.5	98.3	101.1	101.1
Groceries	45.7	43.8	54.4	72.4	66.7	84.1	57.9	51.7	59.2	55.8	54.7
Meats	60.0	47.0	57.7	84.2	83.2	90.2	75.6	77.7	71.2	76.1	75.5
Fresh Vegetables	111.8	31.6	67.0	86.2	53.1	50.7	62.6	59.4	54.8	67.0	97.6
Fresh Fruits	102.7	80.1	83.5	80.2	63.9	82.7	47.4	54.0	62.0	52.0	60.1
Canned Vegetables	82.3	77.6	97.0	91.7	86.3	80.7	74.2	66.9	66.8	65.6	65.9
Canned Fruits	66.0	60.6	72.9	78.7	71.6	75.9	80.2	69.5	67.6	67.3	67.3
Dairy Products	50.6	49.5	54.6	71.7	68.2	73.7	62.2	58.2	68.2	63.2	62.4

to-demand ratio for both residual and distillate fuels is relatively strong. However, prices have responded to bullish forces and are now on a relatively high price level. Prices in producing areas are considerably below the eastern market, and this may bring about some price weakness before long.

Groceries

The composite index moved moderately downward in March, but as April progressed gained strength, which of course is not reflected in the index number shown below, as expanding demand resulted in considerable firming in the price structure of staple groceries. In the final analysis, aggregate supplies of commodities such as flour, cocoa, coffee, sugar, fats and oils, are above average, and this phase alone tends to prevent prices from registering important independent price strength.

Meats

The price trend has moved downward for the past month, and a survey clearly reveals that due to the broad increase in the number of livestock on the farms and an inevitable stimulation in slaughter, the supply of provisions—beef, lamb, and mutton—will hold well above the average of recent years. Meats will not be forcefully affected by intensified warfare. In a word, there are powerful forces working against any important upswing in the price level of meats in general.

Dairy Products

The composite index has reached a new low for the year which is along seasonal lines. The stage is set for a record-breaking rate of production for butter and cheese during the late spring and early summer period which will pave the way for the customary sharp upswing in cold storage holdings. There is no indication that the seasonal low point in prices has been reached. Egg prices are relatively low and even though the increase in the number of laying flocks on the farms appears large, which may prove a factor in curbing seasonal price strength later in the year, nevertheless, prices are sufficiently low to warrant some commitments of April eggs for storage purposes.

The Miscellaneous Group

Prices of staple vegetables such as potatoes and onions increased sharply in early April as compared with a month earlier. This is primarily a seasonal influence. By the middle of May supplies of new vegetables from the south will be abundant, and as a result prices will soon be under considerable pressure. The price trend of fresh fruits also strengthened during the past month, and due consideration must be given to the damage to the citrus crops in Florida during the severe cold spell three months ago. However, there is no danger of any shortage. Canned vegetables have shown some disposition to strengthen, and incidentally, export trade for both canned vegetables and fruits has forged ahead at a rapid pace since the outbreak of warfare. The important phase that must now be watched is new crop developments as regards the yield for 1940.

The Hospital Ladies' Auxiliary in 1872

The editor has been reading with a great deal of interest the issues of *The Hospital Bazaar*, probably the first magazine devoted exclusively to the purposes of the hospital field printed in the United States.

In the first issue, dated November 16, 1874, *The Hospital Bazaar* has this very interesting paragraph, relating to the ladies' auxiliary of the Hahnemann Hospital of Chicago, which portrays the work of the women's auxiliaries of our hospitals almost sevently years ago:

> "The Ladies' Aid Society of the Hospital was organized in September, 1872. Its membership consists of about *fifty* ladies, who, in their organized and individual capacity, have been a most valuable and useful auxiliary of the enterprise. Indeed, without their influence and hearty cooperation, the Hospital could not have survived thus far. The members of this society have done very much in the way of increasing its popularity, of visiting the sick, of assisting the convalescents in procuring employment, both in the wards and out of them, and in finding suitable homes for them after their discharge. They have founded a library for the use of the patients, and given the institution a character and position in community, that could not have been attained without the aid of such an organization. Beside all this, they have collected by subscriptions, benefits, social entertainments, etc., nearly *ten thousand dollars*, with which to pay the current expenses of the Hospital. The officers of this society, for the first two years just closed, were *President*, Mrs. Kate N. Doggett; *Vice-President*, Mrs. L. Z. Leiter; *Secretary*, Mrs. J. S. Mitchell; *Treasurer*, Mrs. R. Ludlam."

Hospitals Day by Day—Some Pointed Paragraphs

WALTER E. LIST, M.D.

¶ While talking to the administrator, the misinformed complainant is not spreading more harmful misinformation.

* * *

Couldn't we all do with 100 per cent census of prepayment plan patients?

* * *

If prepayment plans for the payment of ward patients' bills are established, why should they not include the payment by municipalities, counties, and states at the cost of hospitalization and fees for professional services?

* * *

Couldn't we all dispense with the "attending" who always wants special privileges for his family or friends but who never pays his bills even if a discount has been granted?

Albert W. Buck

¶ From the amount of waste in public and private expenditure brought about by misleading advertisement and self-seeking practitioners who know the commercial value of a fear complex, we cannot escape the inference that we have leaned too far backwards in our effort to stand up straight. The old code of medical and hospital ethics must be revised to strengthen our defenses.

* * *

Quantity purchasing is dependent on the success of the experimental unit. Any study in hospital waste must recommend trial use and trial periods as preventive measures.

* * *

Sickness is a humiliating experience for anyone to endure under any circumstances.

* * *

Another paradox is the faith that many people have in the extraordinary substances that are used in the treatment of disease (such as chemical compounds of complicated formulae) in contrast to the seeming lack of interest in the routine foodstuffs which are, indeed, taken for granted, since they somehow manage to regulate themselves. The psychological explanation for this may be the challenge of the unusual and the mysterious, and the craving for immediate spectacular results from "treatment." The remedy for this condition is at hand, even though it is not universally applied.

* * *

The intelligent hospital administrator, like the captain of a ship at sea, fears the fog more than he fears the storm. He makes full use of instruments of precision in guiding his craft. What navigator, indeed, would ever think of establishing the position of his ship on a sunny day by dead reckoning. He knows the depths of the sea in which he is sailing and, if he is in doubt, takes occasional soundings to make sure.

* * *

The chronic hospital existing independently of the acute general hospital is an expensive and unnecessary luxury.

E. M. Bluestone, M.D.

¶ There are no ills in a hospital that money won't cure.

Henry L. Moses

¶ A deficit is often the symbol of a noble ambition.

S. S. Goldwater, M.D.

¶ The objective of all hospitals should be the best possible service to the patient, and to obtain this end there must be groups of men and women actively and intelligently interested in its affairs, who care more for the welfare of patients than they do for their own. Trustees and personnel must be actuated by the same ideals which in the last analysis is service and subordination of personal interest for the good of the hospital and the patients undergoing treatment within its walls.

To achieve this, the trustees, resident, and visiting physicians, the superintendent, nurses, and the other personnel must have a high, unselfish devotion to duty. The relations between the trustees, the superintendent, nurses, and other personnel, especially the visiting and resident physicians, should be cordial, and each individual should have confidence in his coworkers and admiration for their work.

The paramount interest and endeavor of all, at all times, should be the restoration to health of the patient. *Charles S. Pitcher*

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EDITORIALS

National Hospital Day

During the fifteen years in which the American Hospital Association has officially sponsored National Hospital Day, its observance has grown to such proportions as to give it the character of a major program in public relations. This development has been due largely to the enthusiasm and initiative of individual hospitals and local communities under the far-sighted and energetic leadership of the National Hospital Day Committee.

Last year, of the more than two thousand hospitals that observed this occasion, eight hundred submitted detailed reports of their activities. In addition, twelve hospital councils and sections also submitted reports of their observances. More than three thousand newspaper clippings, ranging in length from a quarter column to a full page, were received by the Committee. Radio time was so generously given, both locally and nationally, that it is not possible to estimate the thousands of radio minutes devoted last year to National Hospital Day.

Aside from the vast good achieved in public understanding and sympathetic appreciation of the work of the voluntary hospital generally, National Hospital Day has become the focal point of a public relations program for each hospital individually. Boards of trustees, women's auxiliaries, physicians, superintendents and hospital employees are being brought to the realization that it is part of their function to understand the relationship of their hospital to its community, and to interpret this relationship not only on National Hospital Day, but throughout the year.

Just as National Hospital Day has in fifteen years developed from the original idea of the late Matthew Foley to an important, nationally recognized annual day of observance, so it will continue to develop until every hospital on this continent participates in a long-range, public relations program based on excellence of service to the community. The realization of this fact will go far to insure continued progress for voluntary hospitals in America.

Hospital Service in the United States

The Council on Medical Education and Hospitals of the American Medical Association has continued the outstanding service which it inaugurated in 1906. The statistical data that the Council collects, analyzes, and publishes each year, since 1921, in the Hospital Number of the Journal of the American Medical Association are the most comprehensive, reliable, and informative that are available to the hospital and medical field.

The report for 1939 is particularly significant. During the year 9,879,244 patients were admitted to our hospitals—one every 3.2 seconds. This is exclusive of the 1,099,713 babies born in hospitals,

almost one-half of the total born in this country. The increase in hospital admissions over 1932 was 459,169. The average census for the year was 996,483.

The total number of hospital beds is 1,195,026, an increase of 33,646 over 1938. The report emphasizes that "this increase is equivalent to a ninety-two bed hospital for every day in the year, including Sundays and holidays."

The average number of idle beds was 198,543, as compared to 195,674 for 1938. Bed occupancy in general hospitals increased slightly, 69.2 per cent for 1939 as against 68.9 per cent for 1938.

One thousand, three hundred, seventy-six state accredited nursing schools, as compared to 1,395 in 1938, reported a student registration of 85,642.

The total of patient days was 368,716,295 for 1939, an increase of 11,233,605 over 1938. The bed capacity of registered hospitals has doubled in the thirty years since 1909.

The administrators of our hospitals are distributed as follows: 2,189 physician administrators; 2,375 nurse administrators; and 1,662 lay administrators who have neither the M.D. nor R.N. degree

The report further analyzes the performance of hospitals by types of service and by ownership and control. It presents the figures gathered in an ordered and dispassionate manner, analyzing them without bias, and in a form that is easily understood.

The work of assembling these statistics is almost limitless. As a contribution to hospital and medical information, it stands alone as authoritative, reliable, and of the largest possible value. The annual reports constitute the statistical history of hospital performance in this country for more than thirty years.

The Council on Medical Education and Hospitals is to be congratulated upon its 1939 report. The hospital field in America is deeply indebted to the Council for the information it has so generously made available.

Hospitals in War

Our country is slowly but definitely, perhaps inexorably, moving closer to participation in another World War. However firmly we may be convinced that the United States should not be drawn into European difficulties, we must be practical enough to prepare for a contingency which every one devoutly hopes may never affect us, but which the crowding events make more than probable.

The medical departments of our army and navy, in their plans for preparedness, are quietly and efficiently preparing for the use of our hospital staffs and organizations. They have asked the hospitals to arrange for personnel for service hospitals which may be needed. The hospitals are cooperating in every possible way.

Our institutions should of their own initiative study what effective adjustments they can make, what personnel they can spare if the need demands, and what changes they can effect that will insure their patients good care and least interrupt the satisfactory discharge of their responsibilities to their communities.

It is certain that the chaos and confusion which were so unhappily experienced in the World War will be replaced with orderly procedures in any future war in which this country may be involved. But the best results will be obtained when the hospitals' trustees and medical, administrative, and nursing staffs give timely thought and planning. By every means, and in all ways, they should cooperate closely with the medical services of the army and navy when they are asked to do so.

Hospitals and Interns

In 1905 the number of physicians graduated was 5606. In 1939 the graduates numbered 5089, a decrease of 517. In the years intervening the number of physicians graduated each year did not vary greatly from these figures, and the product of our medical colleges seems to be pegged at approximately 5000 each year. Practically every college of medicine in this country emphasizes that the present enrollment of medical students is all that they can provide for, and that the saturation point has been definitely reached.

In 1905 the population of the United States was between seventy and seventy-five million. Conservative estimates of the 1940 census figure a population of one hundred thirty-four million, an increase of at least sixty million people. The number of hospital beds in 1905 was four hundred twenty-one thousand, and in 1939 one million one hundred nineteen thousand, an increase of approximately seven hundred thousand beds, all with five hundred seventeen fewer medical graduates.

Only one out of every three persons suffering from sickness and disability sufficiently serious to be incapacitated for the performance of daily occupation is admitted to our institutions in any given year. The remainder is cared for in homes or places of residence.

At least thirty-five hundred physicians either die during the year, become too old or infirm to engage in active practice, or leave their medical practice to engage in other work. This estimate is probably too small and it is quite possible that the number of physician graduates are just about sufficient for replacement of those who die, become inactive, or change to other vocations. This is so in spite of the rapidly increasing population, and the surprising increase in hospital beds—an increase which has averaged twenty thousand a year for thirty-five years.

Hospitals, good hospitals, either at present approved for intern and resident training or those which could meet the standards of approval in a short time and with small effort, cannot find medical graduates for intern and resident service in any way comparable to adequate service. With seventy-five hundred approved internships available, it is impossible to fill these places with 5000 graduates annually.

We are confronted with no theories in this dilemma. It is reduced to the most urgent of practical problems. Either the patients in our hospitals should have the benefit of competent and sufficient intern service, or they must be the innocent victims of professional neglect. Physicians send their patients to the hospitals in the security of the knowledge that these patients will receive better care than if they remained in their homes, and for the further and more personal reason that a larger number of patients can be attended, and in a better way.

Many suggestions of expediency have been made to supplant the intern service with service of another kind. Few of these suggestions can be practically applied and provide the patient with the quality of service which he expects and should rightfully receive.

The hospitals should have the number of interns and residents of the desired professional qualifications if proper professional standards are to be maintained. The practical solution lies either in the increase of students in our medical colleges or in having more medical colleges or both.

If the hospital employed physicians as full residents at a salary which would attract any physician, at least one-half of the applications for these positions would come from recent graduates in medicine.

Hospitals are not now and should never be expected to sacrifice professional service to the false premise that the number of physicians in practice must not be increased as our population grows, and as our hospital beds are added to meet the needs of the growing population.

Anesthetic Gas Explosions

The increasing number of reports of explosions due to the use of anesthetic gases in our operating rooms is a matter of grave concern. Many experienced surgeons are unwilling to dispense with the newer anesthetics. They believe these anesthetics have so many advantages that on the whole they save more lives than they sacrifice. But the character of these explosions and the attendant publicity are so influencing the public that many hospitals have felt it necessary to abandon the newer anesthetics in favor of the older and safe ether or nitrous oxide.

Despite the safeguards which the manufacturers of anesthetic equipment have provided, the modern construction of operating rooms, and despite the training of personnel, the explosions continue, often with loss of life or at least with extensive damage to property.

In the most recently reported explosion the patient suffered a ruptured trachea and died two hours after the explosion. In another explosion a nurse was seriously burned and in still another the surgeon was injured. No one in the operating room is immune.

The patient should not be exposed to these hazards, the surgeon should not have the added worries of the possibility of an explosion, and nurses and other personnel must not be exposed to unnecessary danger when ministering to patients.

In the majority of these explosions the source of ignition is static electricity. Static electricity is generated wherever there is friction—even as little as that arising from particles of dust in an air current. While much is known about the characteristics of static electricity, not enough is yet known to permit complete control of it and elimination of the danger of it igniting the more flammable gaseous anesthetics. Intensive research to this end is now in progress, and results so far seem to indicate that procedures rather than type of equipment are at fault.

In any case, unless and until adequate means of protections from these hazards can be devised and their use assured, the surgeon or the hospital employing these anesthetics is very definitely on the defensive.

A Manual for Field Representatives

The American Hospital Association has, over a period of years, published more than two hundred leaflets, bulletins, manuals and monographs on policies, procedures, methods and statistics relating to hospitals. This year, again, the councils of the Association are preparing and publishing a number of new manuals on such varied subjects as insurance coverage, bookkeeping and accountancy, job specifications, plant standards and specifications, maternity care, psychiatric care and dental care in hospitals.

For the first time in its history, however, the American Hospital Association, through its Council on Association Development, has published a manual about itself. This manual, although intended originally for the purely practical purpose of providing, in convenient form, information for the fifty-five field representatives of the American Hospital Association, was soon found to be of value as a reference source for other members as well.

The manual is an eighty-page pamphlet covering briefly the essentials of the history, purpose, structure and accomplishments of the American Hospital Association. It contains, further, the by-laws of the Association, a description of its headquarters, a list of its technical bulletins and publications, in addition to lists of the various national hospital associations, regional hospital assemblies, sectional hospital associations (state and provincial) and district hospital conferences and councils.

It will be recalled that when the American Hospital Association adopted its new by-laws in the fall of 1937, it became possible for sectional hospital associations, by affiliation, to become official sections of the national organization. A special feature of this manual is a set of by-laws suggested for state and provincial hospital associations wishing to avail themselves of the provisions for affiliation. In a little over two years, twenty-one state associations have so revised their by-laws and several others are now in the process of making the required changes. In nineteen of these associations, membership is now on a joint basis, so that it is necessary to join the state hospital association in order to become a member of the American Hospital Association, and vice versa. Further signs of strength are seen in the notable increase in institutional membership. In two years there has been a net increase of 563 institutional members, bringing the total to a present institutional membership of 2,588.

Representatives in each state and province are charged with the responsibility of interpreting the national organization to prospective members in their localities. The Manual for Field Representatives is intended to provide in brief and concise form a statement of the structure, functions, and accomplishments of the American Hospital Association, and the importance to hospitals and adjuvant organizations of membership therein.

Financing a School of Nursing

JOHN G. BENSON, D.D.

SHORTLY after becoming administrator of my first hospital I was shocked one evening to hear my name being called by newsboys. My name was flung across the newspapers announcing a suit against me for fifty thousand dollars. A charity patient who imagined she had a grievance against the hospital sought to recover damages and her lawyer thought he had hit upon a real winning point by placing me personally liable. The charge against me was that "I was an incompetent nurse." This suit vanished of course but it left me with a twitter of guilt. The charge against me I had to confess was true. I could have helped this sister a great deal if she had thought to ask me to be one of her witnesses. In participating in this discussion I am overwhelmed with the consciousness that as a nurse I am a No. 1 cow-puncher.

I speak neither as a nurse nor an expert financier. I am a layman with sincere respect for the nursing profession in sympathy with the aims and motives at present stirring this great body of trained workers toward greater educational realities. The old order is changing in the field of nursing. From scrub maid, kitchen roustabout, and all around errand girl the nurse has been moving to higher heights of professional efficiency until now the nurse's service to the sick is about as important as that of the other servants of science who compose this modern therapeutic mosaic for the saving of human life.

There are obvious conflicts and contradictions with resulting confusions in the economics of nursing training and nursing service. Nursing is expensive—expensive for hospitals to conduct the training, expensive for the public to pay for the service, and expensive for the nurse herself, due to prevailing conditions peculiar to her profession. We face further, the fact that the average income for a nurse is relatively low, too low entirely for her needs and too uncertain for her necessities, while at the same time the cost of nursing service seems too high for the public to pay.

The New Adjustments

Whether we administrators like it or not we are moving straight into a readjustment of the economic and educational elements involved in the question of nurse training. Administrators of hospitals naturally are trying to solve the problem from the point of view of the financing of schools and nursing while our nurses are trying to find the solution from the point of view of professional and academic standards. The public demands good nursing, and by that we really mean good nursing.

Hospitals must have good nursing, plenty of it, and at a rate that the public can pay for or else we will see ourselves moving into larger socialization of nursing and hospital service. This demand on the part of the public suggests cooperation. The closer the leaders in nursing work with the leaders in hospital administration, the sooner will both interests arrive at higher and more satisfactory ground of economic and professional efficiency.

Economic Problems in Nursing Education

There is at present a feeling of anxiety upon the part of administrators of hospitals due to the new demands of the new curriculum for schools of nursing. This anxiety is occasioned largely by the lack of an understanding interest in the economic resources of the hospital organization to underwrite such advance in educational requirements. The present economic set up of hospitals and schools of nursing has come upon us by the empirical route, poor as it is we grew it out of our own experience. The public helped create it, and the public is always slow to change in anything. Hospitals have grown rapidly, probably too rapidly, and some of our financing is not ideal. However, to place upon the hospitals too great a shock of economic readjustments at this time might result in an unmeasured harm to all interests concerned.

The Author

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To declare that many small schools of nursing must go out of existence, without some appreciation of the totality of the problem involved and provisions made for caring for the hospitals' need, is very short sighted and harmful. This much we say for the benefit of leaders in the nursing profession who are inclined to advocate educational advantages at the expense of hospital welfare. I honestly feel that what some of these leaders need for the good of the whole question is to get a little closer to the historical elements in the problem of the financial administration of the whole set up of the hospital including a school of nursing. While the cooperative construction progress might be slower certainly it is imperative that we leaders in nurse education and hospital administrators move together each appreciative of the other's inherited difficulties.

Financing the Educational Program

Having said this much for the nurses may we say something for those of us who are responsible for the administration of the hospital which means among other things the financing of the educational program for the schools of nursing. We need not have the jitters. This condition is normal, it is found in any profession. The nursing profession is only responding to the demands of the time. Everyone is urged to get an education and nurses are no different. All they are doing is "Getting an education."

Nurses want to graduate from real schools so that they may answer the demands for better nursing. Honestly, when we back off from this question and look at it dispassionately, for the life of us we cannot find any reason to say nay, except that it will mean financial readjustment. Certainly it is going to cost money, it already does, and because we administrators happen to be on the side to provide the money we feel the pinch. We are beginning to feel with the old fellow who complained that his wife was forever demanding money and when he was asked what his wife did with all his money, he said he did not know because he never had given her any. This approaches very closely the situation of the hospital in relationship to the demands of the new program of nurse education.

Heretofore, we have taken student nursing for granted. We have not always been fair with their interests and rights and now we face the problem somewhat confused and disturbed because of a lack of a path of experience to follow.

Again with the administrators of hospitals in mind, may I suggest that instead of loud denunciations in order that we might maintain the "status quo" of the situation that we do some creative and courageous thinking on the economics of nurse education, its rights and aims, and see if there cannot be evolved a new system of financing that will conserve the best in both sides of the issue. With this in mind I will present some of my observations on the subject of financing schools of nursing. I wish that you would note the limitations I have deliberately placed on my subject. They are some "observations" and that is all they are. Furthermore they are observations based largely upon experience I have had in schools of nursing of my own. This experience ranges from a small school of less than sixty students to a large school of more than 300 students with schools in between these extremes. These schools are of various sizes and in various localities from a small community to a city. Keeping these limitations in mind I will endeavor to show some possible solutions which have come to me out of experience on how some schools of nursing have been able to finance themselves.

The Cost of Educating a Nurse

We were obliged to approach our problem from the question of cost. Without this knowledge we could do nothing. When I found out the answer to that question it was my job to set about to find the funds, with the ultimate goal the bridging the chasm between the expense of my school of nursing and the sources of income, or in other words, balance the budget of the school of nursing.

After careful cost accounting by an accomplished accountant the following items were agreed upon as factors in financing our school of nursing, based upon a student enrollment of 300 students:

FINANCING SCHOOL OF NURSING FOR 300 STUDENTS

Maintenance		
Nurses Home operating cost (1938)	$14,183.40	
Heat, light, power, water and maintenance	21,713.70	$35,897.10
Laundry		9,045.90
Food		
Based 3 meals a day for 300 or 328,500 meals @ 19c		62,415.00
Hospitalization		
Based on ⅔ day per month per student @ $5.30 per day		10,600.00
Instruction		
Theoretical and practical instructors		28,582.00
Administration		
16% of administrative overhead		15,789.00
Depreciation and interest		
5% on building and equipment		30,880.00
Total cost of School		$193,209.00
Estimated minimum cost per student for year 1938		$622.00

Earnings of student for advanced Laboratory Practice

Preliminary 5 months hours per month @ $.00....	.00
Freshman 7 months 150 hours per month @ .20....	210.00
Junior 12 months 175 hours per month @ .25....	525.00
Senior 12 months 175 hours per month @ .30....	630.00
	$1,365.00
Plus tuition of three years @ $150.00 per year	450.00
Total credit earned and paid by student.....	$1,815.00
Cost three years @ $622.00.....	1,866.00
Net loss per student (1938)	$ 51.00

It is generally agreed by those who have a right to an opinion that the cost of educating a girl to become a nurse, on the average, is about $650.00 to $800.00 per year. This figure varies according to the particular schools. Some schools are better than others, some hospitals have better management than others but on the whole the above figures are fairly correct. In my own institution it is nearer $650.00 than $800.00 and for the purposes of this discussion we will use the figure of $650.00 or a total of $1,950.00, as the cost of educating a nurse in my school for the year 1938.

In passing we might say, it makes but little difference as to the total cost whether it is under the old curriculum of 1927 or the new recommendations of 1937, the cost on the average providing it is a school that meets the requirements, will be about the figures we have stated. Probably in comparison with the cost of educating a girl in any kind of a college these figures for educating a nurse is surprisingly low. Let any one try to send a daughter to any kind of a college today and try to get through for anything less than $650.00. It simply cannot be done.

Having placed before you a more or less basic figure of our cost of nurse education supported by both the opinions of national leaders and by my own experience, which is supported by the analysis of a public accountant, I will proceed to the second phase of our observation on how "to finance schools of nursing." May I quote to you words of Mrs. Joyce Knudtsgon Kuhn, R.N., Director of Nurses of Rockford Hospital, Rockford, Illinois, on the subject of financing schools of nurses:

"Problems of financing a school of nursing are much more complicated than those found in educational institutions of other types, because of the difficulty in separating the cost of education from the cost of operating the nursing service of the hospital. A good school of nursing should have financial resources adequate to advance its educational program on a high professional level. A school of nursing, like any other professional school, needs to be assured of an adequate and stable income. It is now clear to the majority of people interested in the problem, that the school of nursing should have a budget distinct and separate from the general budget of the hospital with which it is connected.

"To be sure we are only at the threshold of the era of independent incomes for schools of nursing. The pinched budget of practically all of our schools and the unstable financial basis on which they operate is largely due to the fact that through all these years the school has usually been an integral part of the hospital in which it is operated and has been unconsciously, if not consciously, regarded as an asset to the hospital, in that the labor of its student body obviated the payment of cash wages to the nursing personnel."

Having satisfied myself what was the actual cost for nurse education in my institution, I turned to build my budget with the aim of balancing it as soon as possible. I am a believer in a budget, it is very important to me in my financial thinking and operation. Definition of a budget is "a means of telling your money where to go instead of wondering where it went." The school of nursing should have a budget of its own and those in charge of the school of nursing should be held strictly to a budget. In having a budget for my school of nursing I would have not only the expenses budgeted but the income budgeted. I have not analyzed the budget of expense or cost but gave you the more or less total per student. Now I would like to analyze for you our budget of income in making a school of nursing pay for itself.

Making a School of Nursing Pay for Itself

Almost from the beginning it was apparent that the cost of educating a nurse had to be met from some other source than the general income of the hospital. To exploit the patient in the hospital who innocently comes in for an appendectomy but has to take on the job of helping to educate a nurse looked unethical to me. Furthermore looking about over other schools and colleges I found that the recipients of the training carried almost all of the load. Also I remembered that when I went to college I was not paid a salary, nor given a "stipend," a word with less sting to our guilty consciences, for studying to improve myself. The fact of the matter is my school did not even thank me for studying and getting ready for examinations and for working in laboratories and besides they charged me a tuition and laboratory fees and for my books and what not. I naturally asked why should young women who are improving themselves by getting an education given by my institution which would help them to gain a livelihood, equal on an average to that of a school

teacher, be paid a salary, while I, exploiting my patients to help the nurse and exploiting the nurse to help the patient, went out to corner liberal minded people to give me funds to make up deficits caused by my bad business administration. Such a question was disturbing and uncomfortable to me and led me into the financial study of the question with proved results. This state of mind will have to be reckoned with as we point out to you the elements of my budget for the operating of a school of nursing. It was a condition that intellectually and morally made me face a budget both of expenses and income and give due credit to all concerned.

In building our budget of income we found the following possible resources available. Of course you will keep in mind that all these resources were not immediately available. It took a period of time to introduce this budget and to bring the fullest results to pass. It is not a matter of saying presto-change and you have it. It is not as easy and simple as that by a good deal. The fact is that it took a lot of administrative daring and nerve to bring the matter into reality. Reorganization was as important and far reaching as this requiring time and patience.

Tuition From Students

The first source we found for our budget of income was "tuition from the students." This was a logical though radical step and required several years to completely put into effect. It meant that we had to cease paying stipends which varied in amounts to different classes. We began with the preliminaries and at first we had to be satisfied with just stopping stipends to students. To the next class following we charged a small tuition. The next class was charged a little higher tuition and so on until the tuition reached the place where it was dependent upon the corresponding value of the work offered. You must remember you cannot charge tuition unless you have a real school and the amount of tuition is determined by the value of your school. When you have something worth while you can charge for it. And here we feel is the real value of the new curriculum. It may increase your expenses, it will also increase your potential worth.

The first year we stopped stipends, paying for uniforms, books, and what not. It took three years, of course, for this to be effective throughout the school. The next class was charged a $50.00 fee for the three years, and the next class that entered we charged $25.00 a year making the total tuition $75.00. The next year we charged $100.00 and the next year $150.00 per year for the tuition alone. In each of these changes three years were required. In addition to the tuition we added the cost of physical examination upon entrance which was $10.00 and a cost of $9.50 for sick insurance for each girl to be paid each year which took care of 21 days in the hospital. This year just closing we have reached the point where every student in our school is upon the same basis which is as follows: for tuition alone for the three years $450.00, plus health fee, books, and uniforms and expense of graduation. This is the first step against the total expense of $1,850.00 which we regard the minimum cost of the nurse during her course.

There are, we know, problems arising from tuition requirements. There are ways of meeting tuition problems when necessary. We discovered in spite of some scepticism that we soon had far more candidates for our school upon the basis of tuition than we had on the old basis. We found that the students had money or could find money in some way. There were, however, some that had to have help and it was fairly easy to get churches, clubs, and individuals to make what we called "loan scholarships" to worthy girls. As a result we have now nearly twenty scholarships provided which we can loan each year to worthy girls to be paid back after graduation without interest. By this method we have found that no girl worthy of being in the student body needs to be left out just on account of the tuition. The tuition idea is now established with us in our school, bringing not only new money but a new type of student who will seek out the school that gives the best training and the cost of it has but little to do in the end with their decision. When you establish your academic standard and your financial policy you will be surprised how money is found to help a girl pay her tuition.

Building Our Budget

Let us proceed with the building of the budget. We regarded the service our student nurses gave our patients as worth something to the hospital as well as being of value educationally to the student nurses and that the hospital was charging the patient for this same service. Therefore, we evaluated the worth of that service in matter of hours and to the girls in the various classes we credit 25 cents an hour the first year; 35 cents an hour the second year and 45 cents the senior year. The student's account was given credit each term for the total number of hours she had spent on the floor so that by the time she finished her course she received a credit evaluated at about $1,450.00 This plus the tuition she has paid makes a total of $1,850.00 approximately. There is a small remainder we cover by special gifts from individuals who are interested in education only and not in other phases of the hospital life.

We regard, however, that the cost of our school of nursing has been covered with the net result. Before we changed the financial program five years ago we had an annual outlay in stipends alone including, uniforms, etc., of nearly $40,000 with the new program actually in effect we had an income for the year 1939 of a little over $50,000. This is a total gain of $90,000 a year in cash which if you will use your arithmetic you will see is the interest at 3 per cent on $3,000,000. In other words, it would have required an endowment of gifts of $3,000,000 for education to bring us the results to our finances that was brought by this perfectly sane and just method of tuition.

A further result, we have a better school with five times the number of applicants trying to get into our student body as heretofore and we are now affiliated with four Indiana colleges. I might say that in crediting the students with a certain amount for the services they gave the patients in the hospital we also placed in the budget of the hospital the same item and charged to the patient the same item of cost for student nurse service. We try to give our patients the kind of service they wish, which is general duty student nurse and special duty nursing for which they pay according to what they wish. We have lifted the load of nurse education off the shoulder of our givers and placed it upon the shoulders of the students themselves who are the chief beneficiaries of the educational program and on the patients within the hospital who receive the benefit of the service of our student nurses.

Endowments for Nurse Education

We have said nothing so far about endowments or bequests for nurse education. Unquestionably there is a duty on the public or community to give assistance in the education of a nurse by making gifts, bequests, or setting up endowments. When the task of education is set out clearly from the rest of the hospital needs and proper publicity is given we have found that the gifts begin to come. There are people who are interested in education, who do not care for the hospital side and the education of a young woman to be a nurse appeals very strongly to these people.

We are young as far as our system of financing the school of nursing is concerned and yet there has been a gift of $10,000 to be augmented at the death of the donor to $20,000 to be used entirely to endow nurse tuitional loan scholarship. At 5 per cent this fund will yield $1,000.00 per year. We will loan this amount to ten girls on their tuition. The second year this fund will be augmented by another $1,000 and the third another $1,000 and the fourth another thousand with the $1,000 from the first group coming in, so for the next three years your income is $2,000 a year and so on. We figure that in twenty years after this fund is in full effect that we will have a working endowment sufficient to finance practically all student tuitions of the student body of our school of nursing and give an ever increasing budget for our school that will meet the increasing needs of the program of nurse education. Various churches, clubs, and groups have given money to pay the tuition of worthy girls making their gift an endowment to be loaned to girls of the future. Endowments I feel offer a good opportunity to undergird the slack places in my budget for the school of nursing. There is a very definite appeal to the thought of endowing a personality.

We have made use of this plan for financing our schools of nursing in different hospitals of different sizes and found the plan workable. We cannot say, however, whether it will work everywhere. It is natural that such a plan must be made to fit the peculiarities of local situations and we also believe that the average administrator possesses sufficient creative genius to do this if he believes that good nursing education is worth being financed. If this idea is worth anything the believing administrator will build the right technique for its realization.

In conclusion, it is only fair that we point out some of the difficulties we encountered in the problem of financing schools of nursing.

Our Applicants

The making of a real school of your school of nursing will soon attract the young woman who is interested in nursing. We affiliated with three major colleges in Indiana offering a combined course of study which when completed give the R.N. and A.B. degrees. This put us in the catalogues of the colleges. With this we placed our neatly printed school bulletin in every high school in Indiana. We offered three scholarships entirely free to those applicants who attained the highest standards of work in their high school. These scholarships had an immense drawing power. It planted in every high school a new interest in nurse education. Those of you who are connected with churches will find as we did, your churches are fine points of contact and through the pastors, young women are led to seek out your school. The pastors, like the teachers, are close to young women and often guide them to their life dreams. When you lift the standard of your school to conform to the highest standards of nursing requirements young women of worth seek you out. Our experience every time we have gone through this plan of organization of our schools of nursing has

been that both the number and quality of young women applying increase in proportion to the value of the course we offer. The charging of a tuition helps rather than hinders—providing your school has something of value to offer. Human nature regards that which costs something has greater value than a free gift. Make your school worth while educationally and then publicize it by every method you can and you will get the applicants.

The Inertia of the Conservative Trustee

We all have a few conservative, cautious trustees on our board. They want to be cautious, to protect the institution. They would leave well enough alone. They present a problem in any advance move an administrator wishes to make. But if they are convinced that logic is on the side of the new plan and further the average hospital does not have the money to continue to operate a school of nurses at a loss, you will come out all right. I am a profound believer in a Committee on Nurse Education made up of educators and representatives from the nursing group and medical staff with possibly a trustee or two and with a committee of this kind, providing the Board will give it some degree of authority, one will be able to make progress. It was necessary for me to have my Board elect the Superintendent of our City Schools to head my Committee with the Dean of our largest college near by and give this committee power to act before I was able to get by the inertia of some of my trustees.

Problem of the Poor Girl

I think the question of the poor girl has been answered. We cannot see why people should think that girls cannot afford to pay for nurse training the same as other girls pay for college education. But this is a notion that will have to be overcome. Because a girl is poor is no earthly reason why you should take on the responsibility of educating her, especially when you cannot afford it. You lift the standard of your school high enough and you will attract a type of a girl who will make a good nurse and can pay for the cost of it as well, at least for the tuition part. However, there will be fine girls who cannot afford to pay for their training. I have shown you how our plan for financing the school bends to meet this situation with the loan scholarship on tuition. We have found also churches, social clubs, and sororities willing to take on the task of loaning to worthy girls sufficient to pay their tuition. This is a matter of your standard and in publicizing your plan of scholarship help.

The Over Trained Nurse

We face the problem of the so-called "overtrained nurse," the nurse who receives so much advanced training that she no longer can be expected to do the practical nursing she once did and we are obliged to hire others to do the more menial tasks the student nurse once did about the hospital. We hear this sort of a thing often and not infrequently we believe it, I suspect. I think if we will look at it right we will agree that this is as it should be. More and more the doctor is depending upon the nurse. The nurse has become one of the most important factors in the whole process of getting patients well. Hospitals are giving better service all the while and the average stay in hospitals today is just about half what it was twenty years ago, due to the more efficient service the patients are getting. The highly trained nurse is partly credited with this result without question.

The Service Aid or Subsidiary Worker

There has been introduced into our hospital life, resulting from the natural educational development of the schools of nursing which demands a great deal more money, a new worker, a personality called by some the subsidiary worker, the attendant, or the ward helper. In my institution we prefer to call her a *Service Aid.* This young woman has been introduced into the hospital family to relieve the nurse of those duties requiring less technical training and thus conserve her time for the duties requiring more skill.

The service aid, it is to be noted, is an employee and not a student, but should be selected on personality traits such as adaptability, dependability, and integrity; and the more academic preparation the better. She is trained to her duties, made to feel that she is making a valuable contribution to the patient's welfare and works under continuous supervision of the head nurse. Her duties are planned carefully and kept posted in a convenient place. She has an infinite number of duties to perform which heretofore in our institution was done by the nurse. This individual assists or aids all service agents on the floor under the direction of the head nurse and if necessary takes on the work of the floor maid. It is to be kept in mind that the service aid is an employee hired by the hospital working forty-eight hours a week and paid about $45.00 to $55.00 per month.

The nursing profession is looking with favor upon the training of service aids and in the light of this we do not find the process of education of nurses lifting our nurses clear away from our needs leaving us with a yawning financial abyss to bridge over in our hospitals. Service aids or ward helpers properly trained will provide young women who will be able to carry a large portion of service load, at minimum cost. There is no doubt but that the development of higher educa-

tion for nurses is resulting in the creation of another group of young women—call them what you wish—to do practical nursing. They will fill a need not only in the hospital but in the community at large.

The Small School

The small nursing schools have a large problem. They cannot afford the money nor the clinical material necessary to assure a good program of education. Unless they have some endowment that will furnish the funds for trained teachers, and well equipped laboratories, many small schools face hardship, if not annihilation. However, there are at least two ways that this may be solved. One by the service aid or subsidiary worker under the direction of well trained supervisors. This is being done in a number of places throughout the country. Certainly the small hospital should give consideration to this opportunity to solve their problem of nursing. The other way is by affiliation with a larger school which furnishes a group of students for a period of six months or a year at a time.

We have a small hospital of twenty-seven beds affiliated with our school of nursing and every six months we send nine students to the town of Princeton, Indiana, and the nine who have been there are returned to the parent school. The training of these girls go on while they are at the affiliated school and their work is under the same supervision by the State Department of Nursing as the work at the parent school. The affiliated school pays the expenses of the girls while they are at the hospital but their tuition is paid to the parent school. This is a very satisfactory arrangement as far as the small hospital is concerned. It does offer some problems for the parent school in the matter of adjustment of the rotation of the students who are to go to the affiliated school. This may be a suggestion for some of the small schools or hospital in the need of skilled student nursing service who are finding it impossible to finance a school of nursing.

Let us not be alarmed in the least because in this evolutionary process hospitals and nurse training schools are going through we find ourselves confronted with the necessity of an entirely new economic set up for our hospitals. Probably after all it is a good thing that we are obliged to face the cost of nurse education and therefore compelled to make the right people, namely the nurse candidates themselves and the public at large pay the cost and not penalize the poor patient who has enough to worry about in getting well. We by no means need fear the future because of this economic readjustment due to the just demands of nurse education. It is making far better hospitals and far better schools of nursing and finally much better quality of professional nursing at the bedside and who knows but in the end the public will get a better quality of professional nursing together with the trained service of a larger number of practical nurses at a cost the public can afford—at least we hope so.

Hospital Legislation in New York State

The New York State Legislature passed the following Acts in which the hospitals of that state are interested:

Relating to Interns

Senate Int. 1685 permits practice of medicine in a hospital, by physicians and interns on hospital staffs, who have completed not less than four satisfactory courses of at least eight months each in medical schools in this country or Canada, or in a foreign country, or have received a doctor's degree from such schools having a standard not lower than that prescribed for medical schools in this state; also relates to medical students performing clinical clerkship.

Assembly Int. 1420 makes internship of not less than twelve months in a hospital in this country or Canada a condition prerequisite to receiving license to practice medicine.

Relating to Hospital Records

Assembly Int. 150 provides that injured person or legal representative, in case of death resulting from injuries, shall be permitted to examine hospital records relative to treatment and care.

Relating to the Care and Hospitalization of Persons Suffering from Tuberculosis

Assembly Int. 1856 requires temporary state commission appointed to investigate health of inhabitants of the state to investigate subject of care and hospitalization of persons suffering from tuberculosis and of state financial aid for hospitals and means to provide equality of opportunity for scientific care and treatment of tuberculosis, as well as for its prevention.

Legal Decisions of Interest to Hospitals

Recent Decisions

NOTES upon court decisions which affect hospitals, or where the hospital was a party to the litigation.

Whether Negligence of Hospital Was the Effective Cause of Death

Nelson v. Columbia Clinic, Inc., 96 *P. 2d* 575, (*Wash.*)

This was an action by the administratrix of the estate of a patient who allegedly met death as a result of the negligence of the defendant. There was a judgment of dismissal of the case of the plaintiff which judgment was affirmed upon this appeal.

The evidence was that the plaintiff's son, the deceased, had been taken to the defendant hospital following an automobile accident, and that he died on the second morning following this accident. It was also in evidence that the cause of death, as contained in the death certificate, was "Pulmonary edema and circulatory failure due to injury and inhalation of muddy water into lungs." Negligence was predicated upon the alleged fact that defendant's employees had placed the patient in bed near a cold window, his body being only partly covered, and that death resulted from this neglect.

Plaintiff, mother of deceased, testified in substance that her son did not receive all the proper treatment. On the other hand, it appeared that the patient had been given treatment as for pneumonia, and that he had had a special nurse. Of these facts the court made this comment:

> "The appellant's evidence, in as far as it tended to show any lack of care in the treatment of the deceased, was contradicted by evidence produced by the respondent, which tended to show that the care and treatment given by its staff was in accordance with approved methods. But, on a motion for a judgment notwithstanding the verdict, in determining whether a case was made for the jury, we are to consider the evidence in the view most favorable to the appellant.
>
> "The question is not whether the respondent's treatment of the deceased was proper and adequate under the circumstances, but whether there is any substantial evidence or inference from the evidence, from which reasonable minds could conclude that the respondent's failure to properly treat the deceased, admitting improper treatment, was the cause of his death; not necessarily the certain cause, but the most probable cause.

The Washington court then turned to the consideration of language in another case, and quoted as follows:

> " 'It is undoubtedly true that, in determining the cause of a death for which recovery is sought, the jury may not speculate or conjecture as between several causes; that is to say, where the evidence goes no further than to show that death may have resulted from one of several causes, for one or more of which there is liability, and for another or others of which there is none, then the jury cannot speculate or conjecture and return a verdict as for a cause for which there is liability.' "

The court concluded:

> "Considering the desperate state of the deceased when he was brought to the clinic, can it be said that the evidence affords room for men of reasonable minds to conclude that there was a greater probability that death resulted from the respondent's negligent care of the deceased; or, stating the question in another way, a greater probability that death would not have resulted but for the lack of proper treatment?"
>
> "We do not think reasonable minds could so conclude. The jury's verdict, in awarding the appellant her out-of-pocket funeral expenses only and nothing for loss sustained by reason of her son's death, would seem to indicate that the jury was not strongly impressed with the strength of her case."

It is to be noted, that for the purposes of this opinion, the court assumed that the plaintiff had

made out a case of negligence against the hospital, but that in determining whether the hospital was to be held liable, weight and careful consideration was to be given to the question whether the negligence of the hospital could be said to have been the effective cause of the patient's death. In view of all of the evidence, it would seem that the plaintiff's case was defeated by reason of the fact that the patient had been injured in the automobile accident, and had suffered sufficient shock from trauma and exposure to produce his death, independently of treatment by the hospital whether such treatment was negligent or not.

Whether Sanitarium Is Liable for Injury to Drunken Patient

Nelson v. Rural Educational Ass'n et al., 134 *S.W.* 2*d* 181, (*Tenn.*)

From the allegations of the complaint it appeared that the defendant here was operating a sanitarium and that the plaintiff had been a patient in the defendant institution on several occasions. It further appeared that the plaintiff entered the sanitarium of defendant in order to rest prior to an operation, and that while there he became intoxicated, an employee of defendant striking him on the jaw, causing him serious injury.

A judgment was entered in favor of the defendant, and plaintiff appealed, the appellate court affirming the judgment of the lower court.

The bare allegations of the complaint stated a cause of action, on its face, for assault and battery. However, the theory of plaintiff's case seems to have been that the defendant sanitarium was negligent in caring for and in treating him, and that it should have used other means to pacify him. Of this conflict the court said:

> "With respect to the theory that this is an action to recover damages for injuries to plaintiff resulting from a failure of defendant to give plaintiff such care and attention for his safety as the circumstances required (as distinguished from the action for assault and battery), there is not only an absence of specific averments in the declaration upon which such action could be predicated, but there is no material evidence to support such theory. Plaintiff had voluntarily entered the Hospital for the purpose of being 'built up' for a surgical operation. He was entirely sober when he arrived at the sanitarium, and had been sober for some time prior thereto, and remained sober during the period of eleven or twelve days which intervened between his arrival and the evening of December 8 when he became intoxicated. He was under no restraint, and until the evening of December 9 nothing occurred which would reasonably suggest that he should be placed under any restraint. As soon as it was discovered that he was intoxicated, he was placed in the care of a male attendant who, so far as the record shows, was competent and qualified for that duty.
>
> "Considered as a Hospital conducted for private gain, defendant Sanitarium was not an insurer of the safety of its patients. 'While all the authorities hold that a private hospital owes to its patients such reasonable care and attention for their safety as their known mental and physical condition reasonably requires, yet this is always limited by the unbending rule that no one is required to guard against or take measures to avert that which under the circumstances is not likely to happen, or, more accurately, which a reasonable person under the circumstances would not anticipate as likely to happen. The law only requires reasonable care—that care to avert dangers which a reasonable man would take under the circumstances as they exist—and no man does or is required to take measures to avert a danger which the circumstances as known to him do not suggest as reasonably likely to happen. These circumstances include the patient's mental condition and aberrations, and what he is likely to do by reason thereof, the degree of his mental and physical helplessness, and the dangers which his surroundings afford." *Davis v. Springfield Hospital*, 204 *Mo. App.* 626, 218 *S.W.* 696, 699.
>
> "Plaintiff Nelson had been a patient in defendant Sanitarium throughout ten or twelve different periods during the preceding two years, and he stated, in his testimony, that, on those occasions, or some of them, he had been seen by practically all of the defendant's officials and nurses in an intoxicated condition, but there is no indication in the record that he had on previous occasions been unruly, or had showed a disposition to 'fight.' Defendant Sanitarium was not bound to guard against or take measures to avert that which a reasonable person would not, under the circumstances, anticipate as likely to happen."

In general, in cases wherein it becomes necessary to subdue a patient, the hospital, or its em-

ployes will not be held liable provided they use means which are designed only to control the patient, and use measures which do not take on the characteristics of excessive force, or the employment of brutality. In the case under consideration, the cause of action was for an assault, and, the rule is there that unless the employee was actuated by malice, ill will, or an intent to inflict injury, the plaintiff cannot recover. In the case at hand, the striking evidently took place in order to subdue the violence of the plaintiff, and consequently, in contemplation of the law, it was not an assault and battery.

Whether Sanitarium Is Liable for Injury to Demented Patient

Paulen v. Shinnick, 289 *N.W.* 162, (*Mich.*).

These were two actions, instituted by husband and wife, against the defendant, who operated a sanitarium, to recover for injuries suffered by the wife while she was a patient in that sanitarium. There was a judgment in favor of both the plaintiffs, and upon this appeal the judgments were affirmed.

The evidence was that the patient, a mental case, had been accepted by the defendant for treatment in the sanitarium. Defendant had also been fully informed as to the condition of the plaintiff, and made the necessary arrangements for her care. One afternoon the patient complained that she was feeling faint, and her nurse opened a window in the room. However, the inner screen was not locked. Thereafter, the patient requested the nurse to pick up a thimble which she had dropped, and while the nurse was occupied in picking up the thimble, the patient made her way to a chair, climbed upon it, and jumped from the window to the ground, falling three stories. The nurse attempted to restrain the patient by grasping at her skirt, but she was unable to prevent her from jumping.

Unfortunately for the defendant, the patient's condition had been made known in detail, and it was even explained to the defendant that it was necessary to keep the windows locked in order to prevent the patient from attempting to jump from them. The jury returned verdicts in favor of both plaintiffs, and the court denied defendant's motions for judgments notwithstanding the verdicts.

Of the facts the Supreme Court of Michigan made this comment:

> "A jury question was presented. A patient in a private hospital is clearly entitled to reasonable care and attention from the authorities and employees, and the nature of such care will depend upon the attendant circumstances of each individual case, including the known physical and mental condition of the patient. Plaintiff here was admitted as a mental case, classified by defendant's consulting physician as a sufferer from dementia praecox. Defendant was amply warned of her past suicidal tendencies. During a stay of less than one month in "The Haven," Mrs. Paulen was not known to have been violent or to have attempted to destroy herself, although she had continued morbid and upset. On the day the accident occurred, she was very depressed, had refused to eat or to remain in bed during the regular rest period, and had cried and walked the floor. Mrs. Beem, defendant's superintendent, testified that 'any depressed case is apt to commit suicide.' Under these circumstances, it was a question of fact whether defendant's agent, Violet Rose, acted with due prudence in leaving the window and screen unlocked even momentarily and even though she remained in the room. Such a rule is announced by the overwhelming majority of the cases. * * *"
>
> "This does not demand omniscience in the treatment of mental patients. It requires only that reasonable precautions be employed to assure to the patient that care and supervision which the hospital has undertaken to provide. Where there is no intimation that a patient is prone to self destruction, the required watchfulness will be less, as illustrated by the authorities cited by the defendant. Correspondingly, alertness must be heightened where suicide has been successively threatened in the past."

There is a long line of decisions, the facts of which are similar to those of the case under consideration, where the courts have uniformly announced the rule that the hospital owes to such a patient the duty of exercising care commensurate with the known physical and mental condition of the patient. Patently, the rule is flexible, and it must be so, for it is not possible to lay down a rule which can be true of every case, because the facts vary in each one. It is sufficient that the hospital authorities, in dealing with cases of this kind, should exercise an extraordinary degree of care even though, in all instances, the law does not require that such care be exercised. Extraordinary measures may, no doubt, prove costly. On the other hand, law suits are much more costly.

Whether Sanitarium is Properly Served with Process

Bozeman v. Arlington Heights Sanitarium, 134 *S.W.* 2*d* 350, (*Tex.*)

This case involved the question whether there had been proper service upon the sanitarium of a writ, known as a citation, which would uphold the rendition of a judgment by default, entered against the sanitarium, a corporation, when it failed to appear and defend a suit instituted against it for the recovery of the value of services of a person once in its employ.

It appeared that the defendant in this action, Irene J. Bozeman, had filed suit against the sanitarium to recover the value of services rendered to the sanitarium by her deceased husband. A deputy sheriff served a citation on the defendant by leaving a copy of the citation along with a copy of the plaintiff's complaint, at what was apparently the principal business office of the sanitarium, in the hands of a lady in that office. Unknown to the sheriff, the sanitarium had before the time of service, closed its business, and was no longer actively engaged in the work for which it was chartered. The physical plant of the sanitarium had been operated by certain people for their own purposes, with the consent of the owners of the sanitarium.

When the sanitarium failed to appear and defend, a judgment by default was entered against it, and the sheriff proceeded to attempt to levy an execution on its property in his hands. This was the first knowledge that the sanitarium officials had that there was a lawsuit filed against it. Therefore, the sanitarium filed a motion to set aside the judgment by default, upon the ground that it had never been legally served with process. The trial court, in this action, set the judgment aside, and the Court of Civil Appeals affirmed that action of the trial court.

It was said.

"It is a cardinal principle of our jurisprudence that no person shall be concluded by a judgment of a court, either in respect of his person or property, unless he has had an opportunity to be heard. In order for the court to have jurisdiction to proceed to judgment in an action, citation must have been issued and served on the defendant in one of the ways authorized by law, unless he has voluntarily appeared, or accepted or waived process, or unless notice is otherwise dispensed with."

". . . The Arlington Heights Sanitarium, while still a corporate entity, had ceased to exercise its corporate purposes, had closed its sanitarium and offices therein for the transaction of its affairs and its officers and agents were no longer employed or engaged in the discharge of any duty for the corporation, at the time and place where the service was attempted."

Usually, in order for a defendant to be properly served, if a corporation, the summons, or citation, or writ, must have been served upon it by leaving a copy with someone in the employ of the corporation. From that point on, the law presumes that the corporation had notice that a suit had been filed against it. Here, the citation was left with a person not in the employ of the defendant, and although it was left at a place where the corporation had had its principal offices, the corporation was no longer engaged in business at that place. Therefore, the court never acquired jurisdiction of the defendant, and consequently, the judgment by default was erroneous as to the sanitarium.

I have no quarrel with the party system; indeed, I believe that the party system is indispensable to the maintenance of a democratic society. All large political parties are afflicted with insatiable camp followers, and the party in power will always be called on to appease the appetite of hungry hordes, but honest and capable political leaders do not demand that hospital appointments be manipulated to gain votes. All political parties, in my opinion, should renounce any claim to the use of hospitals for partisan ends, and party leaders of the more intelligent sort have been quite willing to do so. When partisan preference replaces merit as a controlling principle in hospital appointments, the inevitable result is a destruction of morale and efficiency.

S. S. Goldwater, M.D., Commissioner of Hospitals, New York City.

Does It Happen in Other States?

After paying $23,662,121 to Ohio workers in the form of Unemployment Compensation benefits during the year 1939, a balance remained in the Ohio fund of $132,486,623 as of December 31, 1939.

Records of Mechanical Operations

EDWARD F. MINER

IN THE fall of 1933 a new steam boiler plant was installed in the New England Deaconess Hospital. With the new plant came the desire to have definite data regarding its efficiency, out of which desire has developed careful records covering five calendar years. These steam and collateral records are thought to be of sufficient value to put in printed form. It is hoped that other hospitals, having definite knowledge of their mechanical operations, will report in such form that results may be compared with the tables submitted here.

The Deaconess Hospital is a privately operated hospital of the non-emergency type, located in the Back Bay district of Boston, near the Brookline town line and serving all types of cases except accident, contagious, and maternity. It consists of three fireproof hospital buildings, a fireproof nurses' home, a brick laundry building and three wood construction buildings of the residence type. At the present time the three hospital buildings have a possible accommodation for 314 beds which with 90 per cent occupancy—always rated as full capacity—would make 103,149 patient days a year.

Having in mind the possibility of improving the service of the hospital, the consulting engineers who planned and supervised the installation of the new boiler plant were retained in an advisory capacity for consultation at any time as to methods of operation as well as for advice and planning for new equipment. The mechanical department was further reinforced by bi-weekly visits of the chairman of the physical properties committee as a supervising engineer, thus bringing all mechanical operations under careful inspection and supervision.

The improvement in the service, which has been marked, has been due to the close contact with expert advice, competent supervision, and careful continuous records of performance. Supplementing the foregoing, weekly inspections of various systems were inaugurated. Notes as to leaks, wastes, or other defects in operation were made out for inspection, all defects promptly corrected and condition reported at the next inspection. Changes were made as soon as possible wherever improved service seemed to warrant. At the same time a general scheme of careful records were outlined to make sure the results obtained by the repairs and changes were worth the cost involved.

The Author

● **Edward F. Miner is Supervising Engineer of the New England Deaconess Hospital, Boston, Massachusetts.**

The accompanying tables are taken from the records of the hospital and give in a general way a review of the efforts made to keep the service of the mechanical plant up to standard efficiency. They constitute a norm or standard by which efficiency can be judged at any time, with data for long periods for all variables. Except for the tables of yearly costs of the department, no costs are shown so the tables may be compared at any time without reference to prevailing unit prices. No tables of electricity are shown as the motors of a large portion of the power used have been in the process of slow change from D.C. to A.C., hence would not produce records for standard reference.

Steam Plant

Steam is employed for all of the operations usual with steam in a hospital, including laundering of all linen, but not including power production. The steam plant consists of three 140 h.p. return tubular boilers with their accessories and operating at a pressure of 100 lbs. It is entirely modern, having been installed the latter part of the year 1933. The furnaces are fired with steam atomizing oil burners, using No. 6 bunker "C" oil. The firing is controlled by hand with no automatic operating devices. A Brown steam flow meter is installed on the flow main and meters all steam produced by the boilers, including that for heating and atomizing the oil. The oil is metered as is also the make-up water to the boilers.

NEW ENGLAND DEACONESS HOSPITAL

BOSTON · MASS

BOILER ROOM RECORDS · DECEMBER · 1939

TABLE NO · 1

DAY OF WEEK	DAY OF MONTH	TEMP. MEAN	TEMP. DEG DAYS	POUNDS OF STEAM	OIL GALS	OIL WT	OIL RATIO S. TO O	MAKE UP WATER GALLONS	MAKE UP WATER WEIGHT	MAKE UP WATER % OF WT. OF S	NOTES
F	1	46	19	181 440	1 680	13 440	13 50	1 312			
S	2	49	16	164 430	1 530	12 240	13 43	1 312			
S	3	50	15	154 980	1 430	11 440	13 55	3 397			
M	4	41	24	185 220	1 760	14 080	13 15	3 285			
T	5	36	29	189 000	1 780	14 240	13 27	2 302			
W	6	39	26	183 330	1 770	14 160	12 94	1 277			Boi. Ch. 1 & 3 to 2 & 3
T	7	40	25	189 000	1 830	14 640	12 91	1 772			
F	8	36	29	202 230	1 940	15 520	13 04	1 400			
S	9	32	33	202 230	1 850	14 800	13 67	1 580			
S	10	44	21	171 990	1 500	12 000	14 33	1 195			
	Sub. T		237	1 823 850	17 070	136 560	13 34	18 832			
M	11	32	33	204 120	1 910	15 280	13 23	1 555			
T	12	26	39	209 790	1 960	15 680	13 36	1 845			
W	13	36	29	196 560	1 840	14 720	13 36	1 872			
T	14	28	37	209 790	1 960	15 680	13 37	1 897			
F	15	26	39	213 570	2 000	16 000	13 34	2 300			
S	16	36	29	198 450	1 810	14 480	13 70	2 107			
S	17	42	23	173 880	1 580	12 640	13 75	1 395			
M	18	41	24	196 560	1 760	14 080	13 96	1 540			
T	19	37	28	192 780	1 730	13 840	13 93	1 665			
W	20	48	17	187 110	1 690	13 520	13 84	892			
	Sub. T		298	1 982 610	18 240	145 920	13 59	17 068			
T	21	38	27	198 450	1 820	14 560	13 62	1 502			
F	22	28	37	206 010	1 870	14 960	13 75	1 140			
S	23	25	40	204 120	1 870	14 960	13 65	1 575			
S	24	22	43	192 780	1 740	13 920	13 85	1 197			
M	25	25	40	192 780	1 750	14 000	13 77	847			
T	26	16	49	228 690	2 100	16 800	13 61	1 495			
W	27	12	53	236 250	2 170	17 360	13 61	1 852			
T	28	21	44	228 690	2 100	16 800	13 61	1 855			
F	29	28	37	215 460	1 970	15 760	13 66	1 705			
S	30	28	37	207 790	1 930	15 440	13 45	1 697			
S	31	26	39	196 560	1 830	14 640	13 44	1 302			
	SUB. T.		446	2 307 580	21 150	169 200	13 63	16 167			
	G.N. T.		981	6 114 040	56 460	451 680		52 067	434 759		
	AVG	33.4					13 54			7.11	

NEW ENGLAND DEACONESS HOSPITAL
BOSTON · MASS.
BOILER ROOM RECORDS · YEAR 1939
TABLE NO 2

MONTH	TEMPERATURE MEAN TEMP	DEG DAYS	STEAM POUNDS OF STEAM	PATIENT DAYS	STEAM PER PA. DA.	OIL GALLONS OF OIL	OIL POUNDS OF OIL	OIL RATIO STEAM TO OIL	OIL GALS. OIL PER PA. DA.	WATER CU. FT. OF MAKE-UP WATER	WATER POUNDS OF MAKE-UP WATER	% M. UP W. OF ST.
JAN	27 8	1 147	6 330 600	8 444	750	56 788	454 304	13 92	6 72	69 596	581 127	9 20
FEB	32 2	920	5 553 920	8 036	691	51 147	409 176	13 66	6 36	59 493	496 467	8 98
MAR	33 2	987	5 992 048	9 182	652	55 881	447 048	13 40	6 08	74 602	622 927	10 40
APR	43 6	640	5 048 190	8 708	580	44 712	357 696	14 11	5 14	66 110	552 019	10 92
MAY	56 4	296	3 979 809	8 943	445	37 061	296 488	13 41	4 14	61 924	517 065	12 99
JUNE	65 6	a 62	2 369 505	8 590	276	21 815	174 520	13 58	2 54	33 885	282 940	11 94
JULY	72 3	a 0	2 206 392	8 713	253	20 700	165 600	13 31	2 38	20 189	168 578	7 64
AUG	73 8	a 2	2 236 640	8 489	263	19 970	159 760	14 00	2 35	16 036	133 959	5 99
SEPT	64 5	a 89	2 787 246	8 158	342	26 200	209 600	13 30	3 21	20 035	167 297	6 00
OCT	54 2	352	4 214 764	8 912	473	39 730	317 840	13 26	4 46	37 215	310 745	7 37
NOV	40 8	727	5 411 070	8 542	634	50 450	403 600	13 41	5 91	58 040	484 634	8 96
DEC	33 4	981	6 114 040	7 879	776	56 460	451 680	13 54	7 17	52 067	434 759	7 11
TOT		6 050	52 244 224	102 596		480 914	3 847 312			569 192	4 752 517	
AV.					509			13 58	4 69			9 10

a - Omitting J.J.A. & S. in total

NEW ENGLAND DEACONESS HOSPITAL
BOSTON · MASS
BOILER ROOM RECORDS · FIVE YEAR AVERAGES 1935-1939
TABLE NO. 3

MONTH	TEMPERATURE MEAN TEMP	DEG DAYS	STEAM POUNDS OF STEAM	PATIENT DAYS	STEAM PER PA. DA.	OIL GALLONS OF OIL	OIL POUNDS OF OIL	OIL RATIO STEAM TO OIL	OIL GALS OIL PER PA. DA	WATER GALLONS OF MAKE-UP WATER	WATER POUNDS OF MAKE-UP WATER	% M. UP W. OF ST.
JAN		1 117	6 325 470	8 123	779	57 010	456 080	13 87	7 02	106 779	891 606	14 08
FEB		1 006	5 840 415	7 663	762	52 601	420 808	13 88	6 86	95 336	795 994	13 62
MAR		857	5 626 684	8 671	650	51 882	415 056	13 55	5 98	99 484	830 688	14 75
APR		586	4 686 048	8 242	569	43 198	345 584	13 55	5 32	86 036	718 401	15 34
MAY		260	3 485 313	8 560	407	33 167	265 336	13 13	3 87	74 582	622 760	17 86
JUNE		a 57	2 184 135	8 194	267	21 139	169 112	12 91	2 58	51 191	427 445	19 55
JULY		a 4	2 057 552	8 124	253	19 242	153 936	13 37	2 37	40 604	339 042	16 48
AUG		a 11	2 009 950	7 770	259	18 592	148 736	13 51	2 39	36 465	304 496	15 15
SEPT		a 117	2 658 111	7 631	348	24 922	199 376	13 33	3 27	61 681	515 038	19 38
OCT		344	4 179 414	8 387	498	38 498	307 984	13 57	4 59	83 371	696 148	16 66
NOV		656	5 012 415	8 124	616	46 386	371 088	13 50	5 71	81 162	677 706	13 51
DEC		1 019	6 015 237	7 811	770	55 246	441 968	13 61	7 08	84 368	704 477	11 71
TOT. 5 YR		29 222	250 403 720	486 500		2 309 415	18 475 300			4 505 295	37 619 005	
AV.		5 844	50 080 744	97 300	515	461 883	3 695 064	13 54	4 75	901 059	7 523 801	15 02

a - Omitting J.J.A. & S in total.

The condensation from the system is returned to the boiler room partly by gravity and partly by steam traps, with a portion of one building served by an automatic electric pump. Any condensation water, unclean to the boilers, is wasted to the sewer as is the condensation from the radiation in one frame building. All other water of condensation, cooling water and water from a five gallon still is returned to the boiler room.

While records shown in the accompanying tables are carefully kept day by day, there is no attempt at the accuracy used in making a scientific rating test of a boiler plant. The records are kept so that future day by day or month by month records may be compared with reasonably accurate standards, for the purpose of quickly detecting at any point a let down in efficiency of either men or mechanisms. There has been no high pressure attempt at extraordinary results to produce a remarkable showing, but there has been a definite aim to produce a high, uniform output.

Steam Tables

Table No. 1 shows a portion of the daily records of temperatures, steam, oil and make-up water for the month of December, 1939. Each day, meter readings are taken of steam, oil, and make-up water of each change of each eight hour shift of the men. Records of mean temperatures are taken from the monthly reports of the Boston Office of the United States Weather Bureau from which data the degree days are derived.

The column for the initials of the days of the week is useful as it identifies Sundays and Wednesdays when, with uniform weather conditions, there is a drop in the use of steam due to the shutting down of the laundry and certain other mechanical operations. Degree days are not figured until the monthly reports of the Weather Bureau are at hand, thus eliminating their daily use, although they are available from any of the daily papers. All meter readings of the three shifts are made up each day and the steam-oil ration figured and recorded. The make-up water detail at first sight seems of little interest, but where there is a fairly uniform demand of mechanical operations, it is a very prompt indicator of trouble.

Table No. 2 shows the monthly records of 1939 collected for a yearly record. As a matter of showing the full monthly records the mean temperatures and degree days are shown for the non-heating months of June, July, August, and September, but no use is made of them in determining totals or averages.

Table No. 3 shows a five year average of the above yearly records which gives very valuable standards for judging the efficiency of the plant. Further it gives long range data for judging steam, oil, and water requirements, both for periods of time and for patient days. The five years of this table, 1935-1939, represents the full calendar years by which the output of the boilers is determined since the steam flow meter was installed.

Oil Records

Table No. 4 analyzes as far as possible the use of oil under the boilers for the foregoing five year

NEW ENGLAND DEACONESS HOSPITAL
BOSTON · MASS.
BOILER ROOM RECORDS · FIVE YEAR
TABLE No. 4 FUEL RECORDS

CALENDAR YEAR	1935	1936	1937	1938	1939	TOTALS	AVERAGE
Gals oil used for year, all purposes	455,394	451,261	461,690	460,160	480,914	2,309,419	461,884
" " " " 4 mo., no heat	79,120	79,280	85,850	86,540	88,685	419,475	83,895
" " " " 12 " ., gen. pur.	237,360	237,840	257,550	259,620	266,055	1,258,425	251,685
" " " " 8 " ., heating	218,034	213,421	204,140	200,540	214,859	1,050,994	210,199
8 months heating, % of total	47.9%	47.3%	44.2%	43.6%	44.7%		45.5%
12 " gen. pur., " " "	52.1%	52.7%	55.8%	56.4%	55.3%		54.5%
Sq. Ft. equiv. direct radiation	52,369	52,369	53,081	53,081	53,081	263,981	52,654
Degree days, 8 mos. heating	6,189	5,905	5,568	5,510	6,050	29,212	5,844
Patient days, 12 months	86,803	95,594	101,579	99,929	102,596	486,501	97,300
Gals. oil per Degree day, 8 mo. heat	35.2	36.2	36.7	36.5	35.5		36.0
" " " Sq. Ft. eq. dir. rad.	4.16	4.08	3.85	3.78	4.05		3.99
" " " Patient Day, 12 mo. all pur.	5.25	4.72	4.55	4.60	4.69		4.75
" " " " " " " gen. "	2.74	2.49	2.53	2.60	2.59		2.59

NEW ENGLAND DEACONESS HOSPITAL
· BOSTON · MASS ·
RECORD OF CITY WATER BILLS · 1939
TABLE No. 5

1ST QUARTER

BUILDINGS	DATE OF READING	METER NUMBER	READING	CU. FT. USED	DAYS CURREAT	CU. FT. PER DAY	1938 QUARTER STD.	BILL COST	NOTES
HARRIS	JAN. 23	1 422 452	4 769 000	139 000	83	1 675	1 654		
PALMER	" "	1 347 143	1 538	291	"	3 506	3 255		
BAKER	" "	1 533 676	1 459	79	"	952	1 424		
DEA. PL. RD.	" "	939 967	512	217	"	2 614	2 719		
" DEA. "	" "	229 740	32 880	320	"	3 855	4 167		
BROADBECK	" "	406 012	243	9	"	108	102		
QR. TOTAL				1 055 000		12 710	13 321	$1 645 55	RATE M$1.56 D$19.83

2ND QUARTER

HARRIS	APRIL 29	1 422 452	4 922 000	153 000	96	1 594	1 551		
PALMER	" "	1 347 143	1 873	335	"	3 490	3 287		
BAKER	" "	1 533 676	1 560	101	"	1 052	939		
DEA. PL. RD.	" "	939 967	768	256	"	2 667	2 759		
" DEA. "	" "	229 740	33 265	385	"	4 010	4 205		
BROADBECK	" "	406 012	252	9	"	94	102		
QR. TOTAL				1 239		12 907	12 843	1 838 75	RATE M$1.48 D$19.15

3RD QUARTER

HARRIS	AUG. 8	1 422 452	5 078 000	156 000	101	1 544	1 525		
PALMER	" "	1 347 143	2 232	359	"	3 554	3 742		
BAKER	" "	1 533 676	1 646	86	"	851	948		
DEA. PL. RD.	" "	939 967	1 036	268	"	2 654	2 578		
" DEA. "	" "	229 740	33 671	406	"	4 020	2 928		
BROADBECK	" "	406 012	276	24	"	238	124		
QR. TOTAL				1 299		12 861	11 845	1 901 75	RATE M$1.46 D$18.83

4TH QUARTER

HARRIS	OCT. 20	1 422 452	5 185 000	107 000	73	1 466	1 416		
PALMER	" "	1 347 143	2 526	294	"	4 027	4 143		
BAKER	" "	1 533 676	1 713	67	"	918	762		
DEA. PL. RD.	" "	939 967	1 231	195	"	2 671	2 691		
" DEA. "	" "	229 740	33 955	284	"	3 890	5 226		
BROADBECK	" "	406 012	288	12	"	165	131		RATE M$1.39 D$20.86
QR. TOTAL				959		13 137	14 369	1 523 02	
YR "				4 552	353	12 895	13 065	6 909 07	RATE M$1.54 D$19.572

period 1935-1939. The division between the use of oil for the general purposes of the hospital and that for house or room heating is derived from the use of oil during the four non-heating months of June, July, August and September. Three times the amount shown for the non-heating months equals the amount of oil used for general purposes for the full year. This amount in turn deducted from the total used for the year gives the amount for heating purposes for the 8 months of the heating season. Although there is some heating in the months of June and September, it is customary in making comparisons to allow this to offset extra heat waste in the mains during the heating months.

The year 1939 shows the largest total quantity of oil used for all purposes. If this amount is adjusted for the 206 degree days and the 6,296 patient days above the average the 480,914 gals. reduces to an amount less than ½ per cent of the average total amount of oil used, a rather remarkable showing of productive uniformity.

The percentages of the totals for the year of the above divisions of oil for heating and for general purposes varies somewhat. That for heating purposes varying very closely with the degree days and that for general purposes varying not quite so closely with the patient days. Because of the two variables, the degree days and the patient days, in the total amount of oil used these percentages cannot vary uniformly.

Seemingly the most interesting portion of this table is in the data of the last four lines. The amount of oil used per degree day for the heating shows scarcely 2 per cent variation. Excepting for the year 1939, the oil used per square foot of equivalent direct radiation for heating and the oil used per patient day for all purposes shows a continued decrease for each year of the period. The oil used for general purposes of the hospital is also quite uniform. All of which shows very consistent work of the firemen, resulting in a very uniform and efficient output of the boilers.

Water Records

City Water Bills—Table No. 5 schedules the city water bills for 1939 as they come in approximately by quarters. The reading of the meters range in lapsed time from 73 to 101 days. These six meters shown take from the city water mains, cover five buildings, with two meters in one building and meter all the water used by the hospital. Secondary meters checking special uses of water in various departments take from the most convenient mains in these five buildings.

It will be noted that the schedule lists the building, date of meter reading, meter number, meter reading, water used in thousand cu. ft., the lapsed days between readings, the average cu. ft. per day passing each meter, the similar record for the previous year and the bill charges. The schedule is kept as a check on the water bills and to tie in with and check the hospital monthly records of water used as per Table No. 6.

The lapsed time between readings of the City Water Department are so variable that there would be no means of fairly approving the bills for payment, unless they were analyzed in some way to a standard similar to the table. It would appear that the city readings, if in error, would be adjusted at the next reading. It is thought preferable, however, to know of any material error when it happens rather than months later as it might be accidentally discovered.

Quarterly Water Records—Table No. 6 covers the detail water records kept by the hospital. They include the same six meters as shown on the city water bills, but the meters are read the first of each month and so can be made to tie in with all monthly hospital records. While the meters are read the first of each month, it is thought sufficient to keep the data by quarters. These quarterly records can be checked with the city water bills on the cu. ft. basis for daily rate.

Of the buildings named in the table, Harris is a nurses' home and dining hall, Palmer, Baker, and Deaconess are hospital buildings and Broadbeck is a frame utility building. Harris is kept to capacity all the time and runs very uniform as to consumption of water as does Broadbeck, excepting in summer when the water is used for lawns. The hospital buildings vary in use of water with the current day census.

The amount of water used in each building is analyzed as far as possible; on the basis of the daily rate in cu. ft. and gallons, on the basis of a percentage of the total used and in addition, for the hospital buildings and the total used, on a patient day basis. Further, on the bottom line is the record of similar amounts for the previous year taken as an average for the full year. The secondary meters taking from the Deaconess mains and metering special services represent such a large percentage of the totals that their records are kept separately and deducted in the table from the record of the city meters serving the Deaconess, so that the Deaconess use of water may be compared quickly with the records of the other hospital buildings.

With the above records every three months and a similar check of the total used each month, the hospital engineer has a very definite knowledge of the use of water in the hospital and further, a very definite indication of trouble, should any

NEW ENGLAND DEACONESS HOSPITAL

RECORD OF WATER USED IN BUILDINGS FROM CITY METERS

TABLE No 6 METER READINGS TAKEN FIRST OF EACH QUARTER

1939 · THREE MONTHS TOTALS AND AVERAGES · 1ST QUARTER

ITEMS	HARRIS	PALMER	BAKER	DEACONESS PIL. RD.	DEACONESS DEA. RD.	DEACONESS SEC. METS.	DEACONESS DEA. ONLY	BROAD-BECK	TOTALS
METER READ. JAN 1	4 735 440	1 465 138	1 442 700	450 403	2 802 804			41 276	
" " APR 1	4 878 852	1 774 234	1 532 200	692 645	3 150 037			50 104	
DIFFERENCE CU. FT.	143 412	309 096	89 500	242 242	347 233	169 534	419 941	8 828	1 140 311
AV. PER DAY " "	1 593	3 434	994	2 692	3 858	1 884	4 666	98	12 669
" " " GALS.	11 919	25 689	7 438	20 133	28 859	14 090	34 902	734	94 772
PATIENT DAYS		8 181	2 596			14 885	14 885		25 662
GALLONS PER P.D.		283	258			85	211		332
% OF TOTAL	12.6%	27.1%	7.8%	21.3%	30.4%	14.2%	36.8%	0.8%	100%
1938 STAND. GALS.	11 699	330	265			88	221		357

2ND QUARTER

METER READ JUL 1	5 018 217	2 097 295	1 611 500	921 511	3 514 924			61 645	
DIFFERENCE CU. FT.	139 365	323 061	79 300	228 866	364 887	153 468	440 285	11 541	1 147 020
AV. PER DAY " "	1 531	3 550	871	2 515	4 010	1 687	4 838	127	12 604
" " " GALS.	11 452	26 554	6 515	18 812	29 995	12 614	36 193	950	94 278
PATIENT DAYS		8 189	2 858			15 194	15 194		26 241
GALLONS PER P.D.		295	208			76	216		327
% OF TOTAL	12.0%	28.2%	6.3%	20.0%	31.8%	13.4%	38.4%	1.1%	100%
1938 STD. GALS.	11 699	330	265			88	221		357

3RD QUARTER

METER READ. OCT. 1	5 163 267	2 446 688	1 695 671	1 181 552	3 884 929			86 557	
DIFFERENCE CU. FT.	145 050	349 393	84 171	260 041	370 005	148 609	481 437	24 912	1 233 572
AV. PER DAY " "	1 577	3 798	915	2 826	4 022	1 616	5 232	270	13 408
" " " GALS.	11 796	28 409	6 844	21 138	30 085	12 083	39 140	2 020	100 292
PATIENT DAYS		7 780	2 535			15 045	15 045		25 360
GALLONS PER P.D.		336	248			74	239		364
% OF TOTAL	11.8%	28.3%	6.8%	21.1%	30.0%	12.0%	39.1%	2.0%	100%
1938 STD. GALS.	11 699	330	265			88	221		357

4TH QUARTER

METER READ. JAN 1	77 318	2 823 962	1 771 700	1 429 992	4 239 318			95 653	
DIFFERENCE CU. FT.	144 164	377 274	76 029	248 440	354 389	156 684	446 145	9 096	1 209 392
AV. PER DAY " "	1 567	4 101	826	2 700	3 852	1 703	4 849	99	13 145
" " " GALS.	11 721	30 675	6 178	20 196	28 813	12 739	36 270	741	98 324
PATIENT DAYS		7 764	2 682			14 887	14 887		25 333
GALLONS PER P.D.		364	212			79	224		357
% OF TOTAL	11.9%	31.2%	6.3%	20.6%	29.3%	13.0%	36.9%	0.7%	100%
1938 STD. GALS.	11 699	330	265			88	221		357

TOTALS FOR YEAR

TOT. USED CU. FT.	571 291	1 358 824	329 000	979 589	1 436 514	628 295	1 787 808	54 377	4 730 295
AV. PER DAY " "	1 567	3 723	901	2 684	3 936	1 722	4 898	149	12 960
" " " GALS.	11 721	27 848	6 739	20 076	29 441	12 881	36 636	1 115	96 940
PATIENT DAYS		31 914	10 671			60 011	60 011		102 596
GALLONS PER P.D.		318	231			78	223		345
% OF TOTAL	12.1%	28.7%	7.0%	20.7%	30.4%	13.3%	37.8%	1.1%	100%
1938 STD. GALS.	11 699	330	265			88	221		357

occur. A very careful inspection is regularly made for leaks of plumbing fixtures. Every reasonable effort is made to prevent waste, but no effort whatever is made to restrict the proper use of water as an abundance of it is one of the prime needs of a hospital.

Cost Data

Table No. 7 covers the detail cost of fuel, electricity, water, tributary labor and supplies, all as reported by the accounting department, the total being as shown in the published Annual Reports of the Hospital. It will be noted that the total departmental costs of all of the items is given, the total of each item, the percentage of each item of the whole costs and the patient day costs in cents. This gives data for an easy comparison for any other hospital which separates out its costs for these items. The costs as shown do not include any general overhead or expense other than that of the engineering department, but does include all other items of costs.

In 1935, the first full calendar year of use, there was added to the hospital plant one new fireproof hospital building containing 35 patient beds and 7,966 sq. ft. of equivalent direct radiation. Similarly in 1939 there was added a wood construction building for a residence of interns with ten beds and 712 sq. ft. of direct radiation.

It will be noted that the total patient day costs for the years 1931 and 1932, the two full years before the year of the installation of the new boiler plant, were exactly the same, at 71.5 cents, although there was a reduction of patient days of 11.6 per cent between the two years. The costs of fuel show a similar reduction of 9.6 per cent with the degree days approximately the same and the patient day costs of this item of fuel for the two years varying 2 per cent. All of these results being without change of radiation or physical plant. This explains the reason for reducing all costs to the patient day basis, patient days being so to speak the output of the hospital.

The years following the installation of the new boilers and the careful supervision, with records, show a marked reduction in the patient day costs and some reduction in the total costs. The patient day costs appear now to be fairly well stabilized at approximately 50 cents per patient day, as compared with 71.5 cents for the years 1931 and 1932. With the present hospital capacity and mechanical equipment any further reduction will be slight and probably must come from some refinement of equipment. The reduction in costs may be otherwise put by comparing the average of the years of 1931 and 1932 with the costs of 1939. For the year 1939 the items in the table have been provided for 37.7 per cent (28.097) more patient days and for 33.1 per cent (23.7 cents) less costs per patient day, with the total cost reduced between four and five thousand dollars. This table of cost data brings out clearly the premise at the beginning of the discussion that expert advice, good equipment, competent department supervision and accurate records of performance may be combined to markedly reduce costs of mechanical operations.

For the purpose of exact comparison of patient day costs, it would appear that an adjustment should be made in the oil column record to provide for the difference in unit costs for the various years. Such adjustment, however, would not materially affect the last column of total costs. For this discussion it seemed preferable to tie the costs in with the published totals of the annual report.

NEW ENGLAND DEACONESS HOSPITAL
· BOSTON · MASS ·
OPERATING COSTS FOR HEAT, POWER, LIGHT, WATER AND TRIBUTARY ITEMS
TABLE NO. 7

YEAR	PAT. DAYS	FUEL			ELECTRICITY			WATER			SALARY			SUPPLIES, ETC.			TOTAL	
	PER YEAR	PER YEAR	% OF TOT.	CTS. PER P. D.	PER YEAR	% OF TOT	CTS PER P. D.	PER YEAR	% OF TOT.	CTS. PER P. D.	PER YEAR	% OF TOT.	CTS. PER P. D.	PER YEAR	% OF TOT.	CTS. PER P. D	PER YEAR	CTS. PER P. D.
1931	79 076	19 023	33.7	24.1	11 691	20.7	14.8	10 463	18.4	13.2	13 834	24.5	17.5	1 536	2.7	1.9	56 547	71.5
1932	69 921	17 206	34.5	24.6	10 891	21.8	15.6	8 558	17.1	12.2	12 477	24.9	17.9	869	1.7	1.2	50 001	71.5
1933	68 112	16 873	35.8	24.8	9 422	20.0	13.8	8 374	17.8	12.3	12 029	25.5	17.7	405	0.9	0.6	47 103	69.2
1934	82 716	14 720	31.8	17.8	10 112	21.8	12.2	7 178	15.5	8.7	13 448	29.1	16.3	848	1.8	1.0	46 306	56.0
1935	86 803	15 292	32.8	17.6	11 148	23.9	12.8	6 696	14.4	7.7	12 386	26.6	14.3	1 093	2.3	1.3	46 615	53.7
1936	95 594	14 807	30.7	15.5	11 531	23.9	12.0	6 641	13.8	6.9	14 017	29.1	14.7	1 212	2.5	1.3	48 208	50.4
1937	101 579	16 482	31.7	16.2	12 205	23.5	12.0	7 327	14.1	7.2	14 868	28.5	14.7	1 145	2.2	1.1	52 027	51.2
1938	99 329	14 210	28.5	14.2	12 732	25.5	12.7	7 450	14.9	7.5	14 284	28.6	14.3	1 257	2.5	1.3	49 933	50.0
1939	102 596	13 622	27.8	13.3	12 999	26.5	12.7	7 219	14.7	7.0	14 127	28.8	13.8	1 068	2.2	1.0	49 035	47.8

Medical Organization of Venereal Disease Clinics at Harlem Hospital

FERDINAND PIAZZA, M.D.

EVERYONE will, no doubt, agree that great progress has been made in the fight against venereal diseases in the last decade. The large attendance at the National Conference on Social Hygiene, under the sponsorship of the New York Tuberculosis and Health Association, held in New York City on February 7, 1940, and the long list of other sponsoring organizations clearly indicated both the intense interest in the subject, and the necessity for greater effort to cope with venereal disease problems.

Since the indigent patient must seek assistance at a free clinic, the out-patient departments of the various municipal hospitals are, consequently, afforded an excellent opportunity to study at first hand the many pertinent phases of public health. The Department of Hospitals is thus a major factor in this venereal disease program and much credit is due its personnel for the success attained so far. The Department of Hospitals is always ready to cooperate to the fullest extent with other interested city departments and social agencies in the prevention and spread of these diseases.

A comparative study of these clinics a decade ago and today will show the great strides made not only in the treatment of venereal diseases but also in the efficient organization of these clinics. There has been a tremendous increase in the attendance of patients to the various out-patient departments of municipal hospitals as a result of state and local legislation, as a result of the increased efforts of the various social agencies and the Department of Health and also because of the lowered economic status of certain communities.

In the Harlem Hospital out-patient department during 1930, there was an average attendance of 100 patients per day three times per week, whereas now we treat approximately 658 patients per day five days per week. Of this number, approximately 50 per cent are syphilis cases, 25 per cent gonorrhea, and 25 per cent dermatological cases. During the year 1939 there were approximately 9,000 patients under treatment exclusive of dermatological cases.

The Author

● **Dr. Ferdinand Piazza is the Executive Physician of the Out-patient Department of Harlem Hospital, Department of Hospitals, New York City.**

Needless to say, in order to wage a successful campaign we must have a well organized, efficient army of doctors. Whereas the medical staff in 1930 consisted of five or six doctors, we now have fifty-five doctors in attendance. Additional personnel, then lacking entirely, now includes three clerks and two messengers to handle the patient's records within the clinic itself under direct supervision of the nurse-in-charge, one full time laboratory technician, a social service worker assisted by a typist and a clerk and a health department staff consisting of a medical social worker, three WPA social scientists and a physician epidemiologist, which staff works harmoniously in close cooperation with the clinic personnel in doing follow-up work in the venereal disease clinics. Although the hospital social service personnel is limited due to circumstances beyond our control, it is, nevertheless, managing rather satisfactorily. The nursing personnel, consisting of one nurse-in-charge, seven regular nurses, and two student nurses, has been found fairly satisfactory for our purposes.

In 1939, the total number of visits made to the syphilis clinic was 95,957, to the gonorrhea clinic 33,413, and to the dermatology clinic 23,697. There were 6,072 blood specimens for Kahn tests taken on cases of suspected syphilis by this venereal disease clinic.

The Syphilis Division of the Clinic

From these statistics, it has been asked with skepticism, "How can such a large number of pa-

tients be treated properly and adequately?" The answer is because we have:

1 An adequate, well organized, well equipped medical staff supervised by two well trained experienced dermatologists.

2 A competent well trained nursing staff, working in perfect coordination with the physician.

3 An efficient social service personnel cooperating with the clinic physician in sorting out delinquent cases, and other pertinent social problems.

4 An adequate and efficient health department staff to follow up delinquent cases, to seek contacts, and to isolate, or hospitalize, infectious cases.

5 An efficient clerical staff.

6 A well planned and well constructed clinic.

The first of the aforementioned factors, namely, an adequate, well organized and well equipped medical staff, will be discussed at this time. As might be expected, the department of syphilology is under the direct supervision of the same medical personnel as the department of dermatology.

As previously mentioned, the medical staff consists of fifty-five physicians. Seven of these comprise the most important group, designated as the Diagnostic Group. This group includes two visiting dermatologists one associate and one assistant visiting physician, and three clinical assistant visiting physicians. This is the only group in the venereal disease clinics which does not receive any financial remuneration. The remaining forty-eight doctors are paid on a per session basis, each attending three sessions per week. These forty-eight paid physicians are divided into two groups, thirty-two of whom are concerned with the treatment of syphilis, and sixteen with the treatment of gonorrhea.

Sessions for the treatment of syphilis are held twice daily and once on Saturday in the forenoon. The attendance of patients has been so planned that at no session are male and female patients both present at the same time. The arrangements which we have found convenient is as follows:

Mondays, Wednesdays, and Thursdays for female patients only

Tuesdays and Fridays for male patients only

Saturday mornings for children up to twelve years of age

The Diagnostic Group

The entire medical staff has been divided into a number of highly specialized groups, the most important of which is the Diagnostic Group as previously mentioned. This unit consists of the two visiting dematologists and five assistants. The attendance of these physicians has been so arranged that at least three are present at every afternoon session. Their function is:

1 To interview all new cases with skin diseases, to take a complete history, and to arrive at a diagnosis for each patient.

2 To treat all patients with dermatological conditions exclusive of syphilis.

3 To interview all patients reacting abnormally to arsphenamine, bismuth, and other similar preparations, in order to avoid possible complications arising from anti-syphilitic therapy; and to treat these complications as soon as they develop.

4 To refer all cases of syphilis to the proper group of physicians.

5 This group may refer any patient for consultation to the neurology or psychiatric clinic or to any other division of the out-patient department or hospital if necessary.

One or both of the attending dermatologists are present at every afternoon session. They both supervise and direct the policies of treatment in the syphilis clinic. They discuss cases, presented to them for consultation, either with the referring physician or in a general conference. One of the visiting dermatologists has undertaken to personally treat those patients who are suffering from the complications of anti-syphilitic therapy. The members of the Diagnostic Group who are interested, are afforded opportunity for research in the field of dermatology and syphilology. In fact, they are encouraged to do this, and it will be found that the administration cooperates with them to the fullest extent.

How the Clinic Apportions Its Medical Staff

The thirty-two of the forty-eight paid physicians, who are concerned with the treatment of syphilis, are apportioned so that approximately nine doctors are present at each session. These nine physicians are further subdivided into four specialized groups, or units, as follows:

The Physical Examination Group—This unit consists of from two to three physicians, located in a section of the clinic which is divided into separate booths, or cubicles, where the doctor and patient are afforded complete privacy. This ar-

rangement is necessary and desirable. The functions of this group are:

To make a thorough physical examination of every new patient referred to them by the Diagnostic Group, prior to receiving antisyphilitic treatment, in order to rule out conditions which might contra-indicate the use of either bismuth or arsphenamine.

To fill out 417V forms used to report the case to the Department of Health, as required by law.

To examine routinely all patients who have had a full course of arsphenamine, or who have completed the required number of bismuth injections, in order to detect complications of treatment in mild form. At this point it may be stated that neoarsphenamine is used routinely at the Harlem Hospital out-patient department. A course of treatment consists of eight injections of neoarsphenamine, the average dose being .45 grams, and twenty injections of 1½ cc dosage of bismuth salicylate, each injection administered at weekly intervals.

To instruct the patient to return to the social service worker after he has received the first injection. Here the patient is given a complete social interview. He is registered and his name entered properly in the follow-up system of records used to detect delinquent cases. The importance of continued treatments is stressed, and an attempt is made to uncover sources of infection and contacts. Also, instructions are given the patient relative to personal hygiene. The patient is encouraged to bring any social problems here for proper solution. If the case is an infectious one, the social service worker, in cooperation with the Health Department staff, makes arrangements to hospitalize the patient and thus aid in preventing the spread of these diseases in the community.

To refer cases for consultation, if necessary, to the diagnostic unit, which is present at every afternoon session.

To refer the new cases to the bismuth, or arsphenamine, treatment group of physicians, as the case may be.

Bismuth Treatment Unit—This group consists of from two to three physicians whose sole function is to give injections of bismuth salicylate. Each of these physicians is seated in a separate booth, or cubicle, which also allows complete privacy for the patient and doctor. A nurse assisting in this clinic coordinates the replacement of unsterile syringes and needles in such manner, that a great many patients can be treated within a short period of time.

After the patient has completed his course of bismuth injections, he is given a complete examination, by the Physical Examination Group. Then, if indicated, depending upon the stage of his disease, the patient is given a rest period. If nothing is found to contra-indicate arsphenamine therapy, the patient is referred to the third group.

Neo-arsphenamine Unit—This unit also consists of from two to three physicians, who limit themselves to the administration of neoarsphenamine. These doctors are accommodated in a large room. On a table at the side of each doctor is placed a tray with syringes containing the proper amount of neoarsphenamine. The patient is called in, sits in a chair opposite the doctor, and bares either arm, which he rests upon the arm-support of the chair. Prior to administering the injection the patient is questioned in order to elicit any untoward reaction resulting from the previous injection. The eyes are examined for signs of jaundice and the skin for purpura. If no previous reaction occurred, and if on superficial examination no abnormalities are detected, the injection is given. This group of physicians may refer any case for consultation to the diagnostic group.

A nurse replaces the empty syringes and a comparatively large number of patients can be treated in a short space of time. Of course, each injection must be given slowly. Following the eighth injection of neoarsphenamine, the patient is referred to the Physical Examination Unit, which unit decides upon the further course of treatment.

The Special Injection Unit—This is the fourth, and last group. It consists of from one to two doctors, who are trained in giving special injections such as tryparsamide, mapharsen, silver arsphenamine, or old arsphenamine, as indicated. Patients who receive treatments other than bismuth or neoarsphenamine are referred to this unit. At the same session these doctors also obtain blood specimens for Kahn tests.

Concluding, then, with the organization of the syphilis division of the venereal disease clinics, attention is called to the fact that once weekly a general conference is held at the end of the clinic session, to which the entire out-patient department staff is invited. Here are presented all interesting cases for consultation and discussion. These conferences have been so interesting and so instructive, that a great deal of benefit has

been derived from them by those who have attended.

The Staff Organization of the Gonorrhea Division of the Clinic

The gonorrhea division of the venereal disease clinics differs slightly in organization from the syphilis clinic. Sessions are held each morning for both male and female patients, who are treated separately in different sections of the clinic by a different group of physicians. There are sixteen paid doctors assigned to this division, twelve of whom are assigned to the treatment of male patients, and four to female patients. Of the twelve, six physicians attend the Monday, Wednesday, and Friday clinics, and six attend the Tuesday, Thursday, and Saturday sessions.

The group of physicians, concerned in the treatment of gonorrhea in the female, treat only gonorrheal endocervicitis. Any patient, presenting such complications as salpingitis, oophoritis or a surgical condition, is transferred to the gynecological service of the out-patient department or referred directly for admission into the hospital. The two physicians work here as a team. One takes a full medical history, and all pertinent facts relative to sources of infection, and prescribes medication for any concomitant condition present, while the second doctor performs a complete pelvic examination, takes a cervical or urethral smear, or both, and applies whatever treatment is necessary. Every case of gonorrhea is then referred for a routine blood Kahn test. Finally, these patients are referred to the social service worker for proper instructions as in the case of the syphilis patients, and for registration in the social hygiene follow-up system.

In the treatment of gonorrhea in male patients, the six physicians are divided into the following three groups:

The Diagnostic Group

The Diagnostic Group—This group consists of two doctors. Their functions are as follows:

To interview all new cases of gonorrhea, and obtain a complete history. An attempt is made to elicit information relative to the source of infection.

To do a complete physical examination and the necessary clinical tests.

To fill out 417V form used to report the case to the Department of Health, as required by law.

To prescribe proper medication.

To refer the patient for a Kahn test of the blood.

Following this initial visit, the patient is referred to the supervising nurse, who instructs the patient in the routine of the clinic. An appointment is then made for his next visit to the clinic. Finally, he is referred to the social service where he receives similar instructions and registration as in the case of the syphilis patient.

The Routine Treatment Group—The second unit is the Routine Treatment Group composed of two doctors, who see all revisit cases. Urethral smears and urines are again taken and examined. Incidentally, smear examinations are done by the laboratory technician, who is present at every session, and a report is given to the examining physician before the patient is allowed to go. In addition, these physicians prescribe further medication such as sulphanilamide, protargol, etc., as desired. Tests are performed to determine whether a cure has been attained. Finally, cured patients are discharged by this group of physicians.

The Instrumentation Group—Finally we have the Instrumentation Group which consists of two doctors, who are well trained in the passing of sounds, and in giving bladder irrigations when indicated. These doctors also administer injections of milk, calcium gluconate, gonococcus vaccine, etc. Patients may also be discharged by this group when cured.

An assistant visiting physician from the urology service receiving no remuneration is placed in charge of the entire gonorrhea division of the clinic. His function is to observe all gonorrhea cases presenting complications, to advise treatment accordingly, and to act as a general consultant.

Summary

To summarize, then, it is quite apparent the entire organization of the venereal disease clinics has been so well planned and organized, that the many individual units, operating in unison, are capable of adequately treating large numbers of patients. We can see, then, how the majority of cases follow a routine plan, and are treated quickly and efficiently, while cases presenting special situations receive intensive study.

It is gratifying to feel that indigent patients residing in our district are treated thoroughly and effectively, with a minimum of wasted time and effort. To relegate venereal diseases to the list of rare diseases is an apparent impossibility at this time. Our goal, therefore, is to induce a sharp reduction in these diseases. We sincerely hope for success.

Maintenance of Floors, Walls, and Ceilings

LUCIUS R. WILSON, M.D., F.A.C.H.A.

THE care of floors, walls, and ceilings is one of the most important maintenance problems of the hospital, if for no other reason than for the fact that every patient and every visitor observes these parts of the physical plant and forms from them some opinion of the hospital's standards. From an economy point of view, it is also well to maintain these constructions properly as they represent quite a large investment. Lack of care will result in deterioration, necessitating expensive repairs and installations. Proper maintenance of floors, walls, and ceilings requires a knowledge of the various materials used in their construction and the supplies which are best adapted for use in each particular instance. There is no one item on the market at the present time that can be universally used in the construction of floors, walls, and ceilings and there is no one material that can be universally used in cleaning and maintenance of them. Therefore, every hospital administrator must acquaint himself with the various products on the market which are best suited to the maintenance of the particular type of construction used in his hospital.

Upon entering any division of the hospital, the floor is the first part of the building to be noticed; so let us start our discussion with it. There are innumerable kinds of floor materials, but fortunately experience through the years has taught us that only a limited number are useful in the hospital and that certain types are to be preferred for special departments. Because of this, most careful consideration should be given to the selection of flooring materials when a new hospital or unit of a hospital is being planned.

Linoleum

Linoleum is more generally used in hospitals for floor covering than any other material. It is moderate in price, can be obtained in attractive colors and patterns, is easy on the feet and is sound absorbing. With proper care it is quite durable and resists staining to a large extent. Its chief disadvantage is that it pits easily and therefore constant alertness is required to see that furniture and pieces of equipment are mounted on gliders, coasters, or casters. The ingredients of linoleum are ground cork and linseed oil, gums, resins and pigments; so in maintenance only those materials can be used which will not destroy these ingredients with particular attention paid to the oil content. The best service is obtained from this flooring by waxing as often as is required from the wear of the traffic load and sweeping with hair push brooms or oil mops. When washing linoleum lukewarm water should be used. If water alone is not sufficient, a small amount of neutral soap can be added. Linoleum should be installed on a concrete base which is not in direct contact with the ground. It may or may not be installed over a felt lining, depending on the degree of resilience and sound absorption that is desired. A cove base is essential for ease in cleaning the junction with the wall.

The Author

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Rubber Flooring

Rubber flooring is being used in increasing amounts in hospitals because of its beauty and durability. It is more expensive than linoleum. Rubber tile can be obtained in numerous plain and marbleized colors and by combining two colors and various sizes of rubber tiles, almost any desired floor design can be obtained. Lately, rubber flooring has been placed on the market in the form of sheet rubber and offered at a much lower price than rubber tile. It also can be obtained in many colors, but of course, does not offer the possibility of numerous floor designs. Rubber flooring does not dent as easily as linoleum, but should be protected where heavy pieces of furniture and equipment are used. It is more durable under heavy traffic conditions than where the traffic is light. This is due to the rubber maintaining its life by constant compression and expansion. This type of floor will oxidize and craze from lack of

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use. The main objection to rubber flooring is the original installation cost and a slight odor which occasionally lingers for a long time.

The maintenance of this type of flooring is quite simple, inexpensive, and limited to few variations. Oils, hot water, alkali washing powders and abrasives must not be used in cleaning rubber flooring. The safest cleaning solution is tepid water and where this does not suffice, a small amount of ammonia can be added. If a glossy appearance is desired, the floor can be polished with a wax approved by the flooring manufacturer. All rubber flooring manufacturers make cove bases of rubber to be installed if desired with this type of floor. Best installations are obtained when the flooring is laid on a concrete base, but other subflooring can be used. It is most important, though, to have the subflooring free from irregularities and permanently dry.

Terrazzo

Where non-resilient, inexpensive, and durable flooring is desired, terrazzo is most generally used. This flooring is a mixture of granite or marble chips and concrete. Wide variations in color can be obtained by using colored cement and mixtures of various colors of chips. Any desired design may be obtained by using brass expansion strips as molds to separate the component parts of the design. This floor is very economical to maintain and easy to clean. Where extreme economy is necessary it can be swept daily and scrubbed with water and a neutral soap when dirty. If the appearance of the floor is essential, it can be waxed and polished with very pleasing results.

This type of flooring wears very well but has many objectionable features which limit the locations in which it can be installed. It is noisy, not restful under foot, stains easily by many solutions in common use in the hospital and effloresces, particularly when new. This latter condition can be prevented to a large extent by properly sealing the floor immediately after it is installed. Terrazzo has found wide popularity as a base and border for other types of flooring because a cove can very easily be formed between the flooring and the base.

Mastic Tile

For economy of installation and beauty, mastic tile is favored. Like rubber tile it is manufactured in many sizes and colors so that attractive combinations are easily obtainable. It possesses resilient qualities, resists staining, and is fairly comfortable under foot. It dents easily, but such mars can be corrected by heating the damaged tile with a blow torch and ironing out the defect. Repairing in this manner, though, usually leaves a surface unlike adjacent tile and often damages the color. Single tiles that have been damaged can easily be replaced. Because of the rapid development of the product, manufacturers have repeatedly changed their color selections and some difficulty in matching colors for replacement often is encountered.

Since mastic tile has an asphalt base, it is attacked by oils; so in cleaning such products as gasoline, benzine, and oily material must be avoided. The use of soap in cleaning this type of floor must be used as seldom as possible and care must be exercised to use only a neutral soap as the grease content of soap will soften and destroy the tile. Maintenance consists of sweeping, mopping with clear water when necessary, and waxing. When waxed, mastic tile flooring presents a very satisfactory appearance, but may be slippery. Only a wax recommended by the manufacturer of the tile should be used. Mastic tile should be installed on a firm subflooring such as concrete. Even when installed under the best obtainable conditions the tile has a tendency to become loose and break. For this reason tiles three-sixteenths or quarter inch thick are preferred over the one-eighth inch thickness.

Asphalt

The troweled form of asphalt flooring differs from the asphalt tile in that it can only be obtained in solid colors; repairing damaged areas requires patching which is difficult and shows the patch. Under wear it often presents an uneven appearance. The same precautions should be observed in its maintenance as in the case of asphalt tile, and even then its maintenance is generally much more difficult.

Ceramic Tile

Ceramic tile is another well known floor material. It provides a surface easily cleaned, is not damaged by frequent wetting, is quite resistent to damage and stains from greases, oils, and chemicals, and can be maintained in a sanitary condition at low cost. Its installation cost is high, but its long life and low maintenance expense offsets this disadvantage and makes ceramic tile floors quite desirable in those areas where a hard surface can be used. Innumerable patterns and color combinations can be obtained by the use of assorted colors and sizes, and most pleasant effects result when used in rooms where tile wainscoting is installed.

Ordinarily, sweeping and mopping will keep this flooring clean and in good condition. Scrubbing machines may be used if desired without damaging the floor. A small amount of volcanic ash or alkaline cleaner can be used in the water

without damage. While strong acid or alkali cleaners will have little effect on the tile, their use should be avoided as they might destroy the cement in which the tile is set. Soap should not be used in cleaning as it leaves a film to which dirt will adhere. The addition of graphite or other similar materials in the manufacture of tile will create a nonslippery surface.

Quarry Tile

Quarry tile is less expensive to install but possesses the same wearing qualities of ceramic tile. Its color range is limited and for this reason it is not widely used. In general, its care is the same as that of ceramic tile and where it can be installed it renders most satisfactory service.

Cement

Cement as a flooring is of limited value in a hospital. It does not present an attractive appearance in its natural finish. When coloring is added to it, the appearance is greatly improved but often after a short period of time the color fades and a mottled and often unsightly condition is the result. Concrete cracks and crazes badly unless an ideal installation has been obtained. Dirt works its way into the cracks and crazes and causes an unsanitary condition. Painting will seal the small cracks and temporarily give a good appearance; however, there is no paint on the market at the present time which will withstand heavy traffic on concrete; so once a concrete floor has been painted, to maintain its appearance painting it at frequent intervals is necessary. Penetrating dyes have been developed to use instead of paint but they are expensive to apply and not entirely satisfactory.

Unless a concrete floor has been properly treated, it tends to dust which interferes with its cleanliness. Routine sweeping of a concrete floor will remove the surface dirt, but when this does not suffice, it should be mopped or scrubbed with plain water. When excessively dirty, scrubbing with water to which soap or an abrasive powder has been added is required. Ordinarily, the use of soap should be limited as it tends to leave a deposit on the surface. Cement floors are occasionally waxed, but unless colored cement has been used in the installation or its surface has been painted, very little is accomplished from this effort. The one thing deciding in favor of concrete floors is the cheapness of the original installation.

Wood

The use of wood floors in hospitals is also quite limited because of the fire hazard and expense of maintenance. Oak and maple wood are the most commonly used materials where a good looking wood floor is desired. These materials are laid in many different sizes and combinations, ranging from uniform width of planks, random width of planks, and parquet flooring, with one or both materials used in combination. Edgegrain pine flooring is used where a nice appearing, less expensive wooden flooring is desired. For places where the appearance is not to be considered ordinary pine or any other wood can be used, depending upon the needs.

To preserve the life and appearance of wood floors, maintenance is a major item. At the time of installation, the pores should be sealed to keep out dust, resist stain, and diminish scratching and marking. After sealing the floor should be thoroughly sandpapered and shellacked or varnished and stained to the desired color. Frequent waxing is essential, especially in areas of heavy traffic. In order to preserve the grain of the wood and prevent the shellac, varnish, and stain from wearing, a wooden floor should be swept with a hair push broom routinely or cleaned with an oiled mop to help preserve the finish. If the appearance of the floor or its life is not to be considered, it can be scrubbed or mopped with warm water and soap, but this treatment is only indicated under rare conditions. The cost of wood floors depends upon the type installed, the effect desired, and the appearance which is maintained. Wood floors may be very cheaply installed and very little spent on maintenance, but such a floor will not be serviceable and will be too unsightly for ordinary hospital use.

Cork

The most silent of all floor materials is cork, but unfortunately it is expensive to install, wears very readily under heavy traffic and is difficult to maintain. Attractive designs may be obtained by using various colored cork material and with considerable effort, its appearance may be kept very attractive. Waxing is essential to this type of flooring to preserve its appearance, to increase the wearing qualities and to facilitate cleaning.

Marble

Where great beauty is desired and the installation cost is of minor importance, marble flooring has found favor. The appearance and cost will depend upon the selection of the type of marble. Wide variations of colors and designs can be obtained. Since dirt does not adhere readily to marble, sweeping with occasional mopping will keep it clean. Neutral soap or mild abrasive can be used in cleaning. The use of strong alkali, ammonia, acids and harsh abrasives should be avoided.

There are many other types of flooring but

their value in hospitals is so restricted that they should be used only after careful consideration of their merits and in locations peculiarly adapted to their qualities.

Walls, Their Construction and Maintenance

Walls, the same as floors, present maintenance problems peculiar to the materials used in construction. For this reason in discussing their maintenance, it will be necessary to discuss the various types of walls used in hospitals. For many years common plaster was used very extensively but during the past few years its use has been limited to walls which will not receive hard service. Plaster may be applied to various types of surfaces such as tile, wooden lath, and metal lathing. Where climatic conditions are not a deterrent factor, galvanized metal lathing is extensively used as it is economical in installation. However, it does not furnish a strong wall and for this reason cannot be used where the wall will be subjected to hard usage.

Plaster

The finished surface of the plaster also enters into the maintenance problem. It may be smooth, sand finished or any one of the various texture finishes. The sand finish is most economical in installation but does not clean as readily as the smooth surface. The textone finish, due to the irregularities of the surface, also presents a difficult cleaning problem. Consequently, a smooth surface is the one of choice in hospital use. A plaster wall should be permitted to dry as long as possible before painting so that the free lime will become absorbed and all moisture evaporated. Free lime forms alkali spots and fading of colors. Moisture in the wall tends to collect behind the paint, causing it to peel. Before painting a plaster wall should be thoroughly sized to seal all pores, to stop suction, and to waterproof. The choice of paint finish on a plaster wall depends upon one's own preference, although the semi-glossy finish is most extensively used. This finish does not have the gloss of enamel, yet has much of its wearing qualities. It does have more gloss than flat paint but will stand washing and age much better than the flat paint. However, there are many good flat paints on the market at the present time and many hospital architects are recommending their uses.

Cleaning the Walls

In cleaning a plastered wall, it has been found desirable to brush it occasionally with a wall brush or mop. This will decrease the amount of washing. When it becomes necessary to wash painted walls, a small amount of neutral soap in lukewarm water is the cleaning material of choice. If this is applied with a sponge, very little damage results to the painted surface.

Keene Cement

When a harder, smoother and more resistant wall than ordinary plaster is desired, Keene cement is used and when a very hard smooth surface to stand unusually hard service is desired, Portland cement is used. After plastering with either of these two cements, the care of walls is very similar to that of the ordinary plastered wall.

To facilitate the cleaning of walls, a dado line is often used. This line is usually about five feet from the floor which is sufficiently high to be above finger marks and dirt spots resulting from people leaning against the wall or the wall being touched by passing objects. The advantage of the dado line is that the part of the wall receiving the greatest use can be more often cleaned without necessitating washing the entire wall. It also affords a stopping point when it becomes necessary to paint a small area.

Painting the Walls

When painting a wall, too much attention cannot be paid to the selecting of the paint. The labor of applying paint is expensive; therefore, it is desirable to secure the best grade of paint so that it will not need renewing at frequent intervals. The following points should be considered in selecting paint: (a) good coverage and hiding power, (b) resistance to dirt, (c) washability, (d) good light diffusion, (e) best color for the purpose, and (f) type of finish.

The Wainscot

In many units of a hospital such as bathrooms, service rooms, operating rooms and treatment rooms a wainscot is desired. Ceramic tile is most commonly used for this purpose, although other tiles such as quartz, slate, glass, marble and rubber are occasionally used. The advantage of the tile wainscot is that it can be washed repeatedly without affecting the finish. It is easy to clean because it is not porous; therefore, dirt and stains do not penetrate. It may be obtained in any color or combination of colors, thereby presenting a pleasing effect. Linoleum has been used both as a wainscot and as a covering for the entire wall. The advantages claimed for it are that it is resilient, does not crack or buckle with moderate settling of the wall, wears easily, is water proof, easily cleaned and installed at low cost. When beauty and durability are desirable marble wainscot or walls are frequently used. Marble is expensive so its use is usually limited to foyers and occasionally to corridors. It can be cleaned very

easily and if luster is desired, occasional wipings with waxed cloths will produce this effect. Another type of wall material which is now being extensively used in places such as kitchens, basements and even corridors in hospitals is hollow tile with glazed surfaces. While not as attractive as other tile it is equally as serviceable and much cheaper to install. Cleaning consists of washing with soap and water whenever needed.

The Hospital Base

Before leaving the subject of walls it might be well to mention the desirability of protecting plastered surfaces by using the so-called hospital base, which usually extends five inches from the floor and slopes to a height of five or six inches. This base keeps trucks, wheel chairs and other portable equipment from damaging the wall. All plastered corners should be protected with beading or angle iron to prevent chipping.

Ceilings

When ordinary plaster is used for ceilings, the construction and maintenance do not differ from that of plastered walls.

Acoustical Treatment

During the past decade considerable attention has been given to acoustical treatment of ceilings and many varieties of acoustical materials are on the market today. The most common installations are those in tile form made of fiber or asbestos squares with aluminum face. Each of these types is perforated to aid in sound absorption and is effective. Usually the fiber tile can be installed more cheaply. The objections to it are that it is not fireproof, cannot be painted although it can be stained with water colors without affecting its sound absorbing qualities and it cannot be readily cleaned. The asbestos type with the aluminum face can be painted and can be washed when necessary.

Acoustical plaster is also extensively used for ceilings but does not have the sound-absorbing qualities of the two materials just mentioned. It cannot be painted or cleaned readily but can be stained with water colors. There are many other types of material less extensively used for this purpose that have merits peculiar to each one; so the choice of acoustical treatment rests largely with the architect and the hospital superintendent.

Wood ceilings are only used for ornamentation in such places as libraries, lounges, and foyers. They are expensive to install and are more difficult to maintain in that repeated cleanings affect the stain necessitating repeated redecoration. Formerly, it was the custom to have the ceilings of a light color, the wall of medium color and the floor of darker color. Present custom has changed this procedure greatly and now any pleasant combination is used and not infrequently the ceiling has a much deeper color than the walls. Such color combinations as these, though, should only be undertaken upon the advice of a skilled interior decorator.

Each hospital will develop its own procedures in maintaining its floors, walls and ceilings, so we have undertaken only to outline general principles to be observed. The building supervisor or the housekeeper should be selected with care for the maintenance work cannot be properly performed without well trained and qualified workers.

A New Grip for Crutches

Entirely new in construction, and designed to give outstanding comfort and safety to crutch users, is a new arm cushion and tip set being introduced by Guardian Latex Products, Inc., of Los Angeles.

The tips, which are being marketed under the name of Safe-T-Grips, are compounded from a new Latex formula which makes them unusually resilient yet gives them long-wearing life.

The size of the Guardian Grips is an outstanding feature. They measure two inches across the base and are three inches high. The entire base forms the walking surface for the grip and sure-footed traction is achieved with two vacuum rings molded into the base. As a result the Grips are said to offer positive protection from slipping even on ice or the most highly polished terrazzo surface.

The Guardian arm cushions are likewise unique in design, being molded from an extra porous Latex sponge. Unusual comfort has been built into the cushions by thickening the Latex along the top and supplementing this with air traps inside the cushion which add to their buoyancy. Particular attention has been paid to narrowing down the side of the cushion. This feature eliminates pinching of the underarm nerves and muscles, thus eliminating the danger and distress of "crutch paralysis."

Completes 17 Years with American Laundry Machinery Company

This year, April 9 had special significance to Paul J. Abrams, Manager of Institutional Sales in New York City and New Jersey area for the American Laundry Machinery Company. Exactly seventeen years ago on that day, Mr. Abrams first became connected with the company.

Prenatal Care

L. GRANT BALDWIN, M.D.

ONE is apt to become so concerned with one's own interests that one fails to comprehend that these interests may not be shared by others, whose desires and problems are along different lines. To an obstetrician it is not understandable that the value of prenatal care could possibly be doubted. Nevertheless, even today many of our lay colleagues fail to appreciate its value, as do some of our medical brethren, if we are to believe the evidence presented by their apparent lack of interest.

In an attempt to illustrate my point permit me to cite two illustrations from my own practice. A few years ago I was consulted by a young primipara who soon told me that she was consulting me against her husband's better judgment. She was an intelligent, fairly well educated woman from a home of rather moderate means. It appeared that her husband's objections were based upon his mother's ideas of the worthlessness of prenatal and obstetrical care. This mother, it seemed, had had six children all without the benefit of medical aid. An old doctor book, printed in the late eighteen nineties, had been her only guide and director. This tome had served her well and in her opinion was still of sufficient value to guide her daughter-in-law through her pregnancy. This example may be an extreme one but, nevertheless, it can not fail to impress those of us, who are smug enough to feel that we, with our admittedly inadequate knowledge, are giving our patients valuable aid throughout their prenatal period.

The second example, I am sorry to say, illustrates the failure of our own confreres. This was brought to my attention just a few weeks ago, again by a young primipara who asked why frequent prenatal visits were necessary. I explained our aims, and she said that she understood, but that her mother-in-law had explained that she could save herself a great deal of bother if she would consult Dr. X., who would see her once during her early pregnancy and again after labor was well advanced! And this occurred not in a rural community with inadequate facilities but in this locality where we feel we are modern.

The Author

● Dr. L. Grant Baldwin is a member of the Senior Obstetrical Staff of the Huntington Memorial Hospital, Pasadena, California.

Need of Public Education

From these examples it would appear that our public still needs education and that our problem is far from solved. There are few who can intelligently doubt the value of prenatal care but it is difficult at times to point out concrete instances of its value to the average patient for our maternal death rate does not decrease perceptibly. However maternal morbidity in patients who have received adequate prenatal care is certainly much less than formerly. In addition there has been a marked decrease in the infant death rate during the first year of life, an appreciable portion of which can certainly be attributed to an improvement in the child's care during its intrauterine existence.

The aim, of course, of all persons interested in this subject is a steady and, we hope, rapid increase in the percentage of our mothers who receive adequate prenatal care and thereby a proportionate decrease in the number of neglected patients, whom one sees too late to help. This type of patient makes up a high percentage of the hospital's maternal death list, and it is of interest to you hospital authorities to attempt to decrease the number of admissions of this type of case. A decrease that can only be brought about by an increase in available prenatal care. This, of course, is the function of the hospitals' prenatal clinic. You as hospital administrators can do little to improve the type of care your private patients receive, except by a careful selection of your obstetrical staff, but you can do a great deal in the control and management of your own prenatal services.

Of the greatest importance is the personnel on

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medical, nursing and administrative services. It is not sufficient to have an efficient and well trained group, but in addition the members of such an organization must have personality and tact; the interest of the patient must be paramount, as the obstetrical patient needs much more than skilled medical care, she craves and deserves understanding, her mental processes are often quite abnormal and an intelligent approach with real understanding on the part of her consultants may do as much for health and happiness as countless prescriptions and misunderstood directions. With this in mind choose those who are to guide the destiny of such a venture.

The physical necessities for a hospital controlled prenatal service are not great and time does not permit a detailed discussion, suffice it to say that no matter how small the space, do not sacrifice privacy; for your patients are for the most part already embarrassed and come to you with misgivings if not fear. Yes, next to cleanliness, privacy with consideration of the patient's feelings must be your ideal. With this introduction may I outline some of your problems? First as they concern a prenatal clinic and second as they concern the private patient.

The Development of the Hospital Prenatal Clinic

The hospital prenatal clinic develops the following from the free or part pay group. These patients as a rule need little encouragement to attend. However, well selected advertising, in an ethical manner, of the existence of such clinics is wise. This can be done by notices in published reports from the hospital, also by various members of the agencies concerned with social services, and by well selected news articles in the daily press. Of course, as elsewhere, well satisfied patients are one's best advertisement. Please do not misunderstand, I am not advocating large prenatal clinics, nor am I advocating attempts to see how many can be interested, but rather attempts to see that all those who are entitled to such care are made aware of the existence of such free or part free services. This, of course, leads inevitably to a discussion of a social service control.

Role of the Social Service Department in the Prenatal Clinic

The social service department of such a venture is of the greatest value, it must be adequate, fair, and honest. It must not be headed by someone who is striving to create the largest clinic of its kind, but rather by someone who has the mental capacity to differentiate between those who financially have a right to belong, and those who are seeking free care when in reality they should be pay patients. Far better a small clinic for the deserving than a large clinic whose enrollment is made up of chiselers and others of a similar ilk. To be adequate, a social service department should be equipped to make personal investigations of the living conditions of the applicants, either by one of its own staff or by affiliation with some already organized welfare agency. No deserving patient should be deprived of prenatal care but likewise no patient, who can afford the usual obstetrical fee charged in a given community, should be encouraged to leave her private physician and to enroll as a clinic patient. If this program is rigidly adhered to, the patient, the doctor, and the hospital will all be fairly treated and will all cooperate towards the goal of better prenatal care for all the community.

Meetings of the Prenatal Clinic

The frequency at which a prenatal clinic should have its meetings depends, of course, upon its size, with a minimum of once weekly. If of any appreciable size more days will be necessary. Such clinics should be supervised by an adequately trained obstetrician. Much of the routine can be handled by the interns but should not be without careful checking. Otherwise both patients and interns will lose much they have a right to expect, the former care and the latter training. It is often wise to designate one day a week or, in small groups, one day a month to abnormal or potentially abnormal patients. This group to be made up of those patients who have a past history of obstetrical pathology and those in whom the routine examinations have revealed abnormalities that may demand special care. The records of such patients should be plainly marked with some easily recognized symbol so that they will be sure to receive the extra care they may require. By segregating this group they can more readily be seen by those best qualified to pass judgment on their needs as pregnancy advances. Many of these needs may not be obstetrical and this of necessity make us think of the advisability of a consulting staff.

Consultant Staff

If the hospital prenatal clinic is part of a well organized out-patient service consultation is usually arranged without difficulty. However, even under such circumstances many institutions have found it desirable to have consultants who will by appointment be available at prenatal clinics, so that patients may be seen without necessitating an extra trip. The pregnant patient should be saved extra visits if it is possible. Such an arrangement, of course, is more feasible in the larger clinics where, for example, all cardiacs are seen on a given day. With such a plan the obstetrician and the cardiologist can each see the patient and

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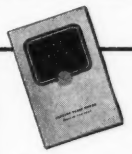

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their combined views based on actual verbal consultation are more to be valued than if each should express his opinion independently on different visits. The triad composed of the cardiac, the tubercular, and the diabetic will make up the bulk of such a consultation practice, but many minor problems will also lend themselves to such an arrangement.

A conference, of those obstetricians who are working in such a clinic, at monthly intervals will do much to sanely answer the obstetrical problems, such as the disposition of the patient with an abnormal pelvis, or one with a bad (obstetrically speaking) past history.

Laboratory, X-ray Service

Other services likewise must be easily available, among them a laboratory, an x-ray department, and adequate dental care. The first, the laboratory, of course the hospital has and, should be available for Wassermann's, urinalysis, blood counts, vaginal smears and suspensions and metabolism determinations. From the second, the x-ray department, we are coming to expect expert aid in the diagnosis of the contracted pelvis. Recently we have been impressed by the work of Caldwell and Molloy on the classification of pelves. This work is of great worth but is not infallible and the obstetrician who forsakes his clinical judgment and relies entirely upon the x-ray will have a sad awakening, it is, however, a most valuable advance towards better prenatal care. And here, let me add, any x-ray taken by other than an expert is worthless from an obstetrical standpoint. All obstetricians have had the experience of having x-ray films brought to them for their opinion, films that have not been taken with the obstetrical problem in mind, and all know that no prognostications can be based upon such evidence.

Finally, the prenatal clinic should have some arrangement for dental care, especially for the extraction of badly diseased teeth.

Educational Program of the Clinic

The hospital prenatal clinic can well engage in some educational program—a library of suitable nontechnical literature. Information regarding layettes, the construction of infant furniture and other necessities will always arouse interest. Movies on prenatal care are available, these could be shown periodically and occasionally at night so husbands can attend. The world's most forgotten man, the expectant father, needs some consideration.

Helping the Private Obstetrical Patient

Hospitals can also help the private obstetrical patient. The foregoing, as far as it concerns the educational program, applies equally as well to private as to clinic patients. It is well for hospital administrators to remember that the obstetrical patients of today will become the older patients of tomorrow. Do not overlook the fact that many, if not the majority, of families have their first contact with hospitals when their first child is born, and their future feelings towards that hospital depend on how they are pleased by the service received at the first visit. So from a purely selfish standpoint all methods that bring private prenatal patients to a hospital should be of value, and, of course, what is far more valuable, all prenatal services are of a real worth to the patient. There are other means that can be used to aid the prenatal patient. Your laboratory is capable of the routines necessary. Some patients find it inconvenient to have such work done in their physician's offices, and some physicians prefer to send all such work out, these patients can well turn to the hospital for help along these lines.

The busy obstetrician is often faced with a situation where his presence is demanded at the hospital by a patient in labor, he may not be actually busy but he can not leave to attend his office, and at the same time some prenatal patient not in labor wishes to see him. If the hospital can arrange space where a physician could see such patients, not as a routine but when necessary, both patient and physician will be served and the hospital will indirectly prosper through the good will of both.

Other Features of an Educational Program

The educational program can be carried somewhat further, periodic lectures on prenatal care, and allied subjects, can readily be given by qualified speakers under the hospital's sponsorship. The majority of hospitals have groups of volunteer workers, these too can help your prenatal program. For example, if your obstetrical patients register in advance their names and addresses are known to you, if not your obstetrical staff can supply this information. There are few primiparae, no matter how much they have been instructed, who are sure their arrangements for their baby are adequate and complete. A well timed call late in pregnancy by a hospital representative, a call intended to check requirements and to make practical suggestions, I am sure would be appreciated by clinic and private patients alike.

In conclusion may I state that we know that hospitals have done much to lighten the load of the prenatal patient. I have only tried to review some well known facts and to present some ideas that may be new to some of you.

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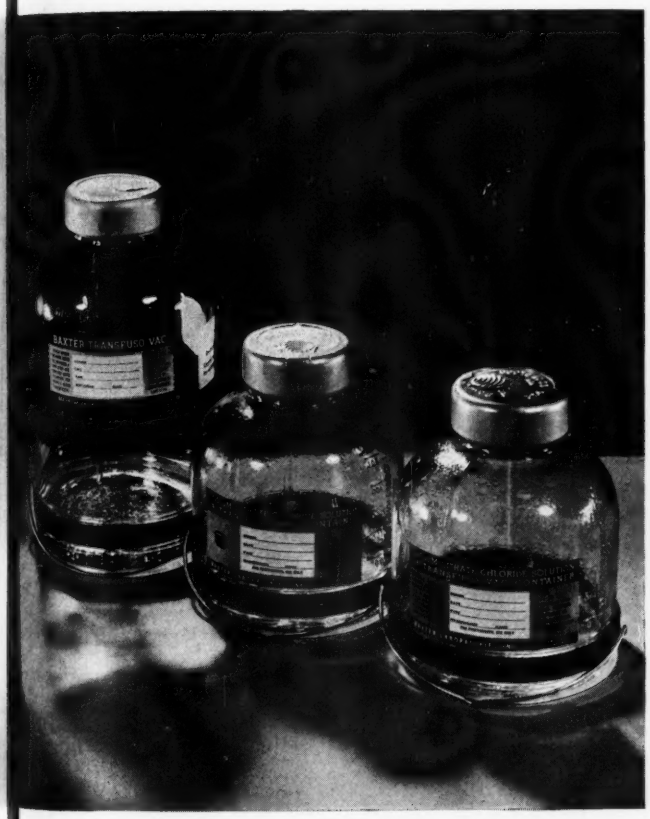

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TRANSFUSO-VAC Blood Transfusion Sets.

IN THE development of its now widely accepted new technique for aseptic indirect Blood Transfusion, Baxter has been guided by these same considerations of convenience and economy in use.

With the Baxter TRANSFUSO-VAC, Drawing the Blood, Citrating, Transporting, Storing, Filtering and Infusing are all accomplished in and from a single vacuum container, bridging both time and space without break in asepsis. Procedure is almost automatic in its convenience, enabling one operator to perform the entire sequence with remarkable economy of time and effort, and without wasting a drop of blood.

Citrate* contents are supplied in three quantities—for 250, 500 and 750 cc. of Blood. Accessory sets are provided for every important requirement.

For the average hospital, the safe rule is to stock two more TRANSFUSO DONOR SETS *than the maximum number of blood transfusions per day.*

*2½ Sodium Citrate in Physiological Solution of Sodium Chloride in the Baxter TRANSFUSO-VAC Container

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SUPPLY CORPORATION • NEW YORK

Preparation, Control, and Technic in Handling Parenteral Solutions

P. BERMAN, M.D.

THE importance of proper care of intravenous and subcutaneous solutions in a hospital has greatly increased in the last several years as the use of this class of medication has become a matter of routine in certain patients in medicine and surgery. In Los Angeles County Hospital more than 100,000 quart bottles of solution have been administered during the last year.

In the preparation of all parenteral solutions there is one important fact to keep in mind: the product must be free from bacterial contamination. There was time, not very long ago, when the administration of 1000 cc's of intravenous solution to a patient was a serious matter as reactions, sometimes severe, were expected in a large percentage of cases.

The cause of these reactions was not well-known. Chemical impurities, the speed of the administration, the temperature of the solution, foreign matter contained in new rubber tubing, variation in the hydrogen ion concentration—all these have been considered at various times as the possible causes of these reactions, but it has been shown experimentally in recent years that none of these could be blamed.

The real cause of the difficulty was found many years ago when Dr. Florence E. Siebert showed conclusively that certain bacteria which are found in water almost everywhere, will cause a typical reaction if introduced into the body. It was found that the substances which caused these reactions were not destroyed by ordinary sterilization even when the bacteria were killed. In fact, it was shown that the solution containing these bacteria will cause more severe reactions after sterilization. These so-called "pyrogenic substances" are apparently the cause of all reactions when intravenous or subcutaneous solutions in large quantities are administered.

These scientific investigations were not applied to practical use for a long time. At present no one who is interested in the preparation of intravenous solutions doubts the fact that the most important single factor causing reactions are these pyrogenic substances.

If we keep in mind the fact that these bacteria are found almost everywhere and that a clean solution cannot remain in an open container for more than a short time before it is contaminated, and that the most important precaution in preparing a good solution is to keep these bacteria and other products out, the problem is not a very difficult one.

Preparation

To prepare any solution for intravenous use, we must have, first of all, clean, uncontaminated water. Ordinary distilled water is not free from these pyrogenic substances unless the still is especially constructed to prevent spilling over of contamination for the main waterline. But it is not necessary to have the water double or triple distilled in order to free it from pyrogens. An ordinary still with extra baffle plates to prevent spilling over could supply clean, distilled water in a single distillation.

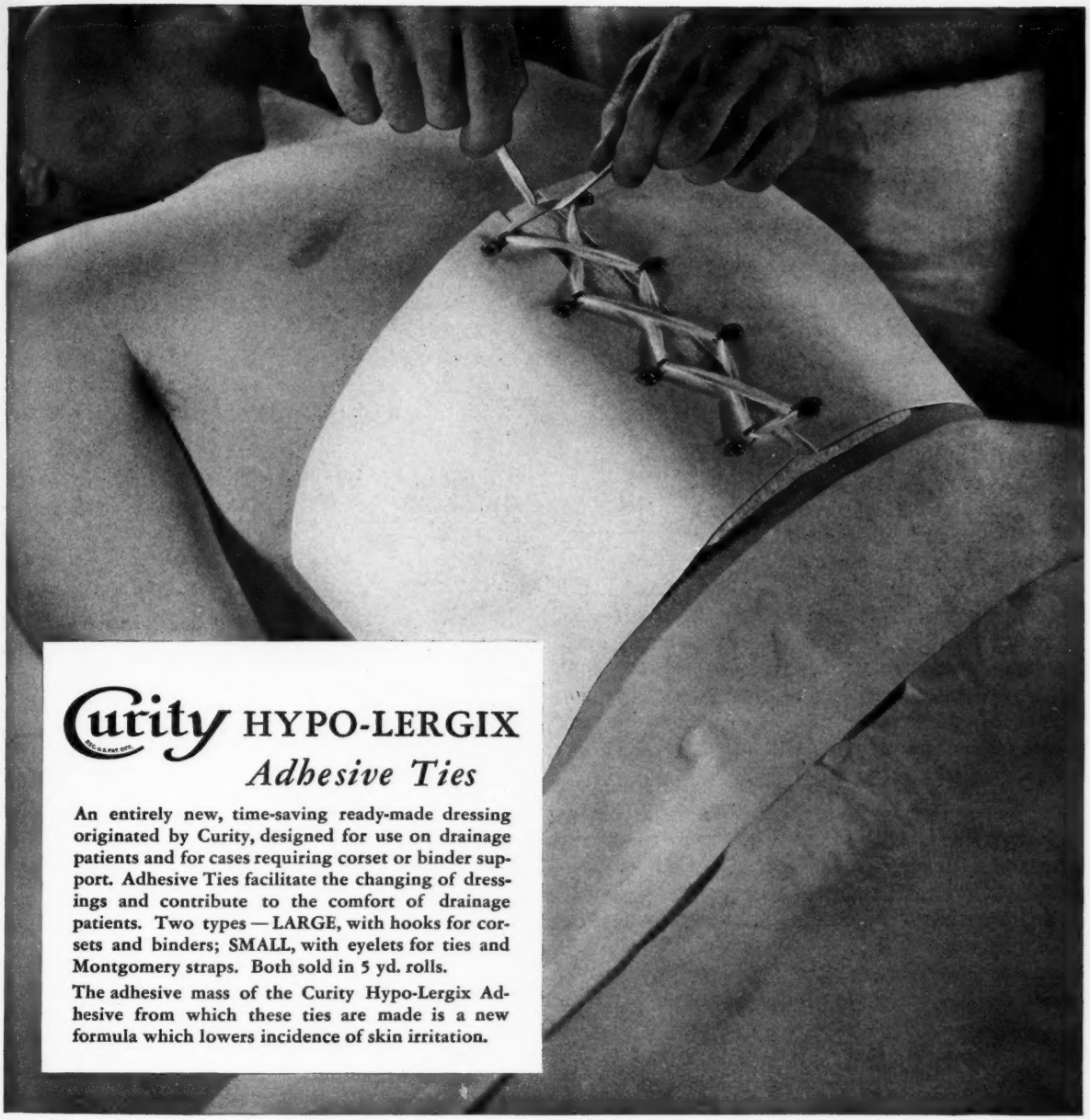
Care must be taken to see that the water does not become contaminated after it leaves the still. It was shown that water standing as short a time as four hours after distillation in the ordinary laboratory will become contaminated. It is best, therefore, to use the water immediately after it leaves the still. If a storage tank is used, it must be kept scrupulously clean and sterilized with live steam, or put in the autoclave daily. This will diminish the possibility of heavy contamination.

Chemically pure ingredients are not expensive, especially if materials are bought in fairly large

The Author

● Dr. P. Berman is Chief of the Medical Service, Los Angeles County Hospital, Los Angeles, California.

Presented at the Los Angeles Conference of the American College of Surgeons.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The adhesive mass of the Curity Hypo-Lergix Adhesive from which these ties are made is a new formula which lowers incidence of skin irritation.

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quantities. Chemically pure anhydrous dextrose costs approximately 15 cents a pound. Chemically pure sodium chloride is more expensive but the amount used in any solution is comparatively small. We found that a certain brand of salt, which could be obtained on the market for about two cents a pound, is of approximately the same purity as the chemically pure salt obtained from pharmaceutical houses although it is not labeled as such. This is the so-called "butter salt," or salt used in dairies for salting butter. We have used this salt for the last several years without any difficulty.

Filtration

After the solutions are prepared, they are immediately put through a filter. Here care must be taken to prevent contamination with pyrogenic substances. Suction should be used to speed up filtration in order to shorten the time consumed in the process as much as possible. This may result in some particles of the filter being sucked into the solution. This is of no clinical importance as solutions containing a great many such particles do not cause more reactions than those which are absolutely clear. However, it is not desirable to have a solution in which large particles of matter are visible to the naked eye.

A Berkefeld filter will give a clear filtrate; but the apparatus must be cleaned with special cleaning fluid and sterilized daily in order to prevent contamination. The Los Angeles County Hospital at the present time is using a Zeiss filter in which compressed asbestos plates are used as filtering material. This gives a clear fluid and has some added advantage. It is claimed that the asbestos plates may remove pyrogens by adsorption.

Glass Containers

Soft glass bottles are not desirable for the storage of intravenous solution. Although it has been shown that the solution of glass, even in comparatively large amounts, has no deleterious effect on the patient, it is difficult to store salt solutions in a soft glass container. The silicates in solution will crystallize when left standing and may be seen as showers of glass crystals to the naked eye.

But it is not necessary to employ the more expensive hard glass. Glass manufacturers now supply glass bottles made by a special method; very little of this glass goes into solution. These containers, which are not expensive, are used in our hospital with good results.

Containers from which the solution can be dispensed directly to the patient without having to transfer it to some other vessel are preferred. This minimizes the possibility of extra contamination. The solution is placed in the bottle as soon after preparation as possible and immediately capped with an ordinary metal screw cap with a rubber insert. Bottles, of course, must be scrupulously clean before use. They are washed carefully with soap and water and rinsed several times with distilled water.

Sterilization

Solutions are sterilized at 15 pounds pressure for about 18 minutes. It was found that with ordinary clean water and chemically pure ingredients, no carmelization will take place at this temperature.

When large quantities of solution are prepared, it is best to have a special sterilizer for the purpose. An ordinary autoclave will deteriorate very fast due to chemical reaction of solution on the metal.

After cooling, the bottles are washed, labeled and stored for use. A solution which was properly prepared, free from contamination, and hermetically sealed, could remain so indefinitely and may be used without danger a year or more later. It is best to stamp a date on the labels of all solutions to indicate the particular batch in which they are made. This will help in identifying the solution when a reaction occurs.

It is advisable to prepare one kind of solution at one time in order to prevent the possibility of mistakes in labeling.

It is best not to use the solutions immediately after sterilization. The prepared bottles should be kept in storage for at least 10 days before use. They are then carefully inspected before they are released from the laboratory. This is especially necessary when soft glass bottles are used. Occasionally glass crystals will develop in solutions after a few days standing. After the bottles have been carefully inspected, they may be kept in the drug room or on the wards indefinitely as long as they remain hermetically sealed.

Administration of Solutions

In administration of a solution a length of about five feet of rubber tubing is attached through a special dispensing cap; the bottle is inverted and hung approximately four feet above the patient. The physician is then ready to insert the needle and start the injection.

It usually takes about 45 minutes to an hour for 1000 cc's of solution to be injected intravenously when a 21 gauge needle is used. The speed

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Try on a pair and you'll feel the difference immediately. Molded so **transparently thin** and so **correct, anatomically**—they allow hands to do the most delicate work unhindered. All Seamless Standard Surgeons' Gloves are identified by the familiar seal which appears on the wrist of the glove and on the box.

That's why Seamless Standard Surgeons' Gloves are an economy every surgeon welcomes

TACTILE PERCEPTION can be dull or keen, depending on the glove. Fingers cramped or free. The surgeon who has made comparisons knows this well and *always* wears featherweight Seamless Standard Surgeons' Gloves. He scarcely feels them on his hand.

And the buyer who compares knows that these tissue-thin gloves are *tough, that they last longer, that they save money.* So, for economy's sake—as well as for the surgeon's sake—make it a point to specify Seamless Standard Surgeons' Gloves on every order.

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Three types are available at your supply house: WHITE LATEX and BROWN LATEX, no finer at any price; also BROWN-MILLED, peerless at their price and most popular of all surgeons' gloves.

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of administration could be varied by lowering or elevating the bottle.

The patient's arm may be placed on a padded wooden splint and in patients who are restless or unconscious, it is best to have the arm taped to the splint. The splint may be fixed to the bed if necessary. This is especially of value in a public institution where it is difficult to provide special nursing care to watch these patients.

To facilitate the absorption of fluid in hypodermoclysis often hot-water bags are applied to the area injected. These hot-water bags have caused a great deal of trouble in some hospitals. The patient is occasionally burned by an excessively hot-water bag, as patients are not as sensitive to heat in the area where a subcutaneous injection is given. We do not apply any hot-water bags in such cases, but when indicated apply a hot compress for 15 or 20 minutes.

The kind of rubber tubing used has no influence on the result of the injection. Pure gum rubber will stand sterilization and wear well. But any kind of tubing can be used provided the tube is clean and free from foreign substances. The special preparation of new tubing is not necessary. New tubing is carefully washed; care is taken to remove any particles of talc or other foreign substances in the lumen of the tube. The tube is then sterilized in the ordinary way and is ready for use.

General Considerations

As the causes of reactions following intravenous and subcutaneous injections are due entirely to bacterial contamination, it is necessary to guard against this from the beginning of the preparation of the solution until it reaches the patient.

Pyrogenic substances are soluble in water and may cause reactions when minute quantities have been added to the solution to be injected. It is necessary, therefore, to have all apparatus used scrupulously clean and free from contamination. If the tubing has been contaminated with water containing pyrogenic substances, it will be difficult to free it except by careful washing. Sterilization alone will not help.

In hospitals where the same containers are used over and over again it is important that empty bottles be not used for any other purpose on the ward. The same bottle should never be used for blood transfusions, as it is very difficult to clean a bottle which contained blood.

Conclusion

Solutions for parenteral use may be safely prepared in hospitals where a large amount of these are required and where someone could be detailed to keep a careful check on all the phases of the preparation. Reactions could be entirely eliminated if a well-prepared solution is carefully administered and when ordinary precautions are taken to prevent contamination. The most important thing is to keep in mind the fact that reactions are due to bacterial contamination which can be eliminated with modern methods of preparation and handling.

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The Man in the Glass

When you get what you want in your struggle for gain,
And the world makes you king for a day,
Just go to the mirror and look at yourself:
And see what that man has to say!

He's the one you must ponder beyond all the rest,
For he's with you right up to the end
And you will have passed your most difficult test:
If the man in the glass is your friend.

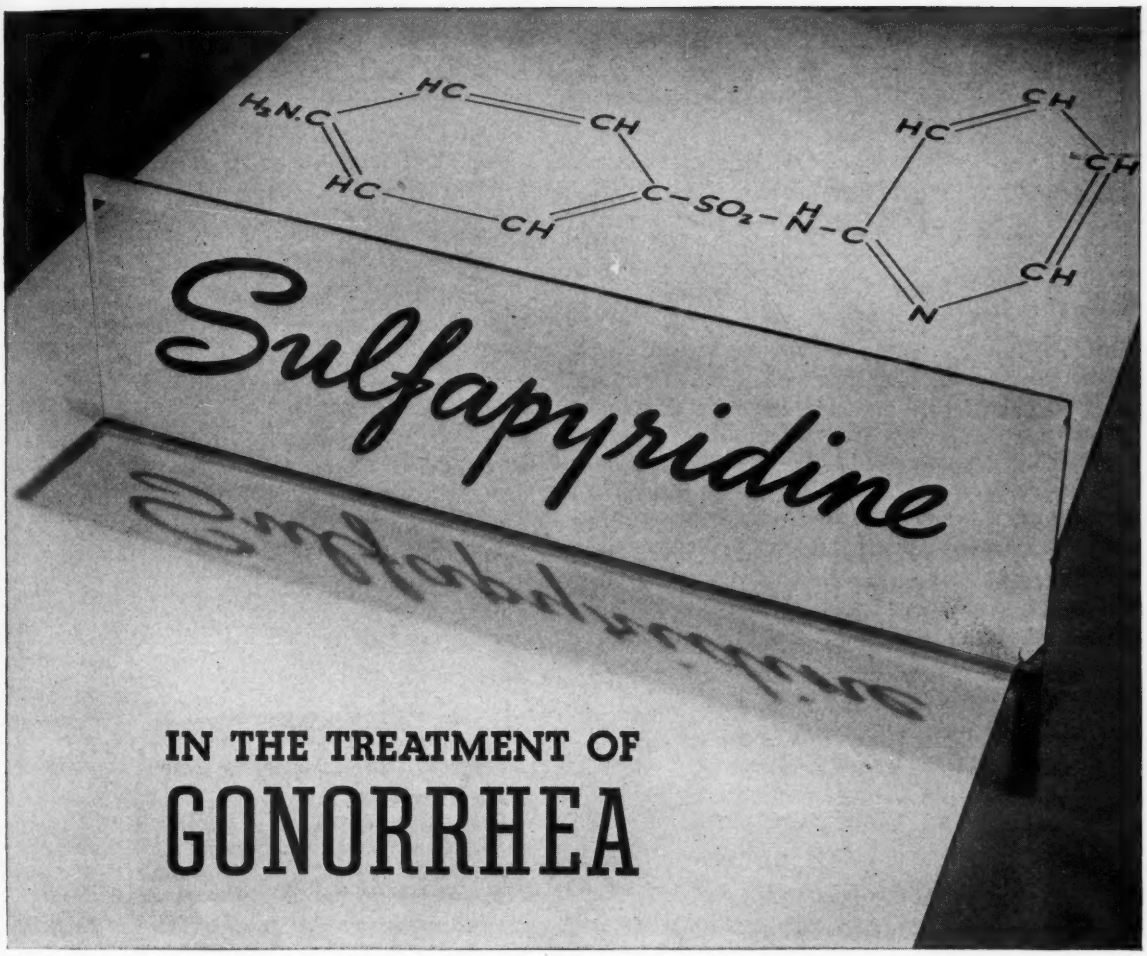
You may be one who got a good break—
Then think you're a wonderful guy;
But the man in the glass says you're only a fake:
If you can't look him straight in the eye.

Anon.

TRENDS IN NURSING HISTORY. Elizabeth Marion Jamieson, B.A., R.N., and Mary Sewall, B.S., R.N. W. B. Saunders Company. 1940. $3.00.

In this text the authors have brought the breath of life to a usually dry subject.

This presentation of the subject should not only prove very interesting to the student, but leave her with a much better integrated conception of the history and development of nursing than is possible in the mere matter of fact presentations to which they have been accustomed. The authors have grasped and used the fact that there is real romance in the development of all arts and sciences if we are but patient enough to correlate their facts with each other and with other apparently unrelated events.



In view of the dramatic therapeutic action of sulfapyridine in pneumococcic pneumonia and its established superiority over sulfanilamide in the treatment of this disease, investigations were undertaken to determine the efficacy of sulfapyridine in the treatment of gonococcic infections.

The results obtained in these clinical investigations indicate that sulfapyridine is a valuable chemotherapeutic agent in gonorrhea and suggest that it may be more effective than sulfanilamide in the treatment of this condition.

Thus it appears that in sulfapyridine the physician has at his command a potent therapeutic weapon for combating this widespread and distressing disease.

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Literature on request

MERCK & CO. Inc. *Manufacturing Chemists* **RAHWAY, N. J.**

To the Holders of American Hospital Association Bonds

THE Board of Trustees of the American Hospital Association has authorized the calling of $7,500 each of the GENERAL MORTGAGE and FIRST MORTGAGE Gold Bonds of the Association at par value and earned interest as of close of business on July 1, 1940.

With the calling of these bonds, the capital indebtedness of the Association will be so reduced that the total of this indebtedness may be discharged within the next few years.

Under the terms of the Trust Indenture, and by action of the Trustees, these bonds must be amortized through payment of stated sums to their amortization funds. The money used for the redemption of these bonds has been the accumulation of the moneys paid into the amortization fund for the redemption of bonds for the past several years.

Below is the official notice of the calling of the bonds:

Notice to the Holders of

AMERICAN HOSPITAL ASSOCIATION, INCORPORATED

First Mortgage Fifteen-Year Six Per Cent. Gold Bonds Due July 1, 1947:

NOTICE IS HEREBY GIVEN that pursuant to the provisions of the Trust Indenture dated July 1, 1932, executed by American Hospital Association, Incorporated, to First Union Trust and Savings Bank, as Trustee, the undersigned has elected to redeem on July 1, 1940, at the principal sum thereof and accrued interest thereon to July 1, 1940, $7,500 par value bonds of said issue bearing the numbers hereinafter set forth, which numbers have been selected by lot as provided in said Trust Indenture. The numbers of the bonds so to be redeemed are as follows:

$100 Denomination

C 14	C 61	C102	C153	C171	C203	C228
15	62	103	154	175	204	232
16	63	117	155	177	206	234
17	67	133	157	178	207	235
25	68	134	158	180	211	237
32	75	137	159	182	217	316
38	76	139	160	193	220	319
41	77	141	165	196	221	322
43	78	145	167	197	223	323
54	79	150	168	198	226	
57	89	151	169	199	227	

On July 1, 1940, there will become due and payable on each of the above numbered bonds at the office of The First National Bank of Chicago, Chicago, Illinois, the principal sum thereof and accrued interest thereon to July 1, 1940. Holders of the above numbered bonds are hereby notified to deliver said bonds on or after July 1, 1940, for payment and redemption at the office of said The First National Bank of Chicago, Chicago, Illinois.

Interest on the aforesaid numbered bonds will cease on July 1, 1940.

AMERICAN HOSPITAL ASSOCIATION, INCORPORATED
By ASA S. BACON,
Treasurer.

Notice to the Holders of

AMERICAN HOSPITAL ASSOCIATION, INCORPORATED

Twenty-Year Six Per Cent. General Mortgage Gold Bonds Due January 1, 1946:

NOTICE IS HEREBY GIVEN that pursuant to the provisions of the Trust Indenture dated January 1, 1926, executed by American Hospital Association, Incorporated, to Union Trust Company, as Trustee, the undersigned has elected to redeem on July 1, 1940, at the principal sum thereof and accrued interest thereon to July 1, 1940, $7,500 par value bonds of said issue bearing the numbers hereinafter set forth, which numbers have been selected by lot as provided in said Trust Indenture. The numbers of the bonds so to be redeemed are as follows:

$500 Denomination

D 5 D13 D15 D21 D23 D25 D26 D31 D39 D40

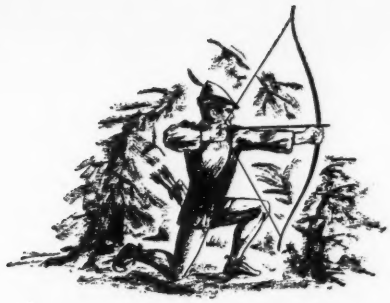
$100 Denomination

C 19	C 28	C 47	C 65	C 85	C114
23	36	50	69	87	119
24	38	59	75	106	125
27	44	63	84	113	162
					194

On July 1, 1940, there will become due and payable on each of the above numbered bonds at the office of The First National Bank of Chicago, Chicago, Illinois, the principal sum thereof and accrued interest thereon to July 1, 1940. Holders of the above numbered bonds are hereby notified to deliver said bonds on or after July 1, 1940, for payment and redemption at the office of said The First National Bank of Chicago, Chicago, Illinois.

Interest on the aforesaid numbered bonds will cease on July 1, 1940.

AMERICAN HOSPITAL ASSOCIATION, INCORPORATED
By Asa S. Bacon,
Treasurer.



"AS THE STRING TO THE BOW . . ."

Only by intimate group cooperation can a medical organization and its workers both achieve their greatest usefulness. As a basis for such cooperation, the place and the candidate must be matched with all possible care and judgment.

To perform this service of bringing together the place and the worker is The Medical Bureau's sole function. In this work the Bureau is guided by policies which years of experience have shown to be indispensable . . . .

M. BURNEICE LARSON, DIRECTOR

- Every inquiry is treated confidentially.
- Every problem receives individual and personal attention.
- The work is divided into its two logical functions:

  Analyzing the applicant's qualifications, and acting for his or her interest.
  Analyzing the requirements of the place, and acting for the institution.

The Medical Bureau each year serves many thousands of institutions and candidates, not only within the United States and its possessions but also in South America. Its services embrace institutions—and individuals—throughout the hospital and medical field.

Institutions are invited to file their requirements with the Bureau, in order that they may find qualified workers confidentially, with the least possible delay and expense. *Individuals* are invited to send for our registration forms, in order that they may more directly locate their logical place and opportunity.

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Among the Associations

The Tri-State Hospital Assembly, hospital associations of Illinois, Indiana, Wisconsin and Michigan participating, will be in session from May 1 to May 3; headquarters at the Stevens Hotel, Chicago. This Assembly will attract an attendance of 3,000 or more hospital people from the four states and elsewhere throughout the United States. It is one of the largest meetings of hospital groups of the year. The full report of the proceedings of the Tri-State Hospital Assembly will be published in the June issue of HOSPITALS.

Hospital Associations of Iowa, Kentucky, and Arkansas

As *HOSPITALS* goes to press, the state associations of Iowa, Kentucky, and Arkansas are holding their annual conventions. The programs for each of these conventions have been well arranged, and will attract a very large attendance of hospital people in their respective states. A full report of the conventions of these states will be printed in the June issue.

The Association of Western Hospitals

The annual convention of the Association of Western Hospitals and the Western Conference of Catholic Hospitals attracted an attendance of approximately 2,500 hospital people in Los Angeles April 8 to 11, inclusive.

The meetings of the various sections were characterized by friendliness and enthusiasm, and a diligent application to the purposes of the fine programs.

In point of attendance and interest the 1940 meeting set a new high.

Los Angeles and its citizens were most generous in the welcome extended the delegates and guests, and the Hon. Fletcher W. Bowman, Mayor of Los Angeles, officially proclaimed April 7-13 as "Hospital Service Week" in that city.

Headquarters of the convention was the Biltmore Hotel, and it admirably accommodated all of the meetings, in addition to the display of technical and educational exhibits. One could not but be greatly impressed with the physical arrangements—the 130 exhibits conveniently and artistically arranged, the use of the Biltmore Bowl for general assemblies, and the various conference rooms for sectional meetings. These last included sections on accounting, auxiliaries and volunteer workers, dietetics, executive housekeepers, medical record librarians, medical social workers, nurse anesthetists, pharmacists, physiotherapists, public hospitals, purchasing agents, and small hospitals. At all of the group meetings, excellent programs were presented.

This great hospital week was opened by the Western Conference of the Catholic Hospital Association whose meeting commenced Sunday, April 7. Special guests from outside the areas included Fred G. Carter, M.D., president of the American Hospital Association; Rev. Alphonse M. Schwitalla, S.J., president of the Catholic Hospital Association; Rev. Paul R. Zwilling, president of the American Protestant Hospital Association; James A. Hamilton, president of the American College of Hospital Administrators; Malcolm T. MacEachern, M.D., associate director of the American College of Surgeons, and others, all of whom contributed substantially to the program.

The program fittingly centered around four major topics: "The Spirit of Hospital Service," "Institutional Policies," "Building Esprit de Corps," and "Building Good Will." Each topic was presented by the main speaker at a general assembly in the Biltmore Bowl. This is a beautiful room with the most modern acoustic facilities, accommodating a thousand people. The leader of the forum which followed the presentation of the topic was ably supported by a panel of speakers who answered numerous questions relating to the theme of that particular assembly.

On Monday morning, the Small Hospital Section meeting was addressed by Dr. Malcolm T. MacEachern on the subject, "Can the Small Hospital Meet the Minimum Standards of Approval?" An extensive panel round table conference followed the address. The facts brought out very distinctly at this session were that the small hospital is, in many communities, rapidly becoming the health center of its community. As such, its opportunities for service are unlimited. Because the small hospital in rural areas represents the focal point

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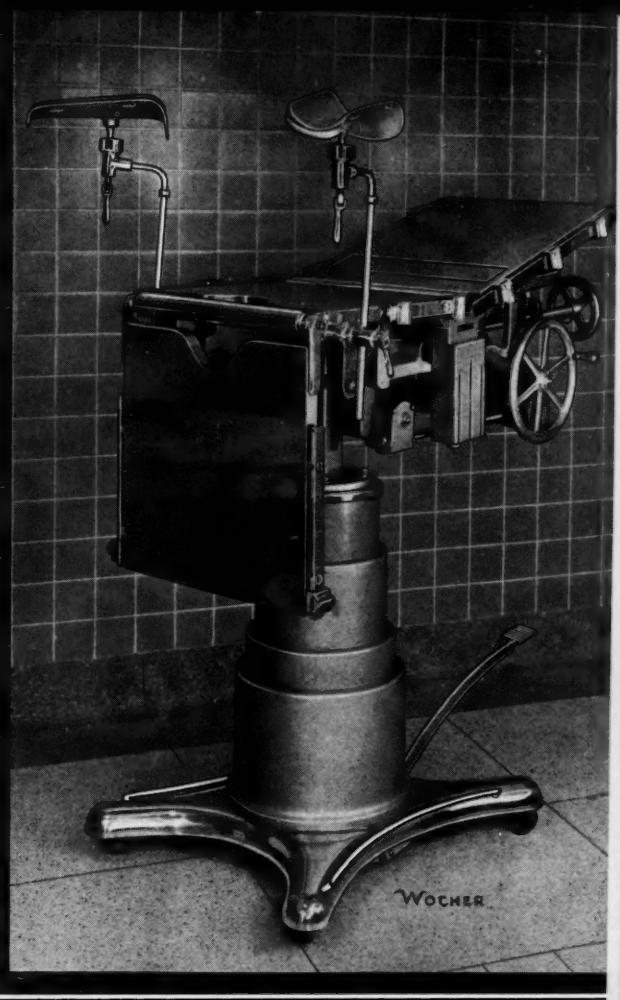

It brings the patient up to eye-level. No more back-breaking bending or stooping. If you prefer to stand while doing Vaginal, Rectal, Brain or Bronchoscopic operations you need a Mont R. Reid table.

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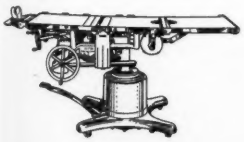
- **Separate Gall Bladder Bridge.**
- **Monolift Single Pedal Pump.**
- **Patient-Weight Counterbalance.**

The new Reid table has a new and exclusive "accelerated action" which moves it into position **faster—easier!**

In direct competition with other makes, 25 new-model Reid tables were chosen for Charity Hospital of New Orleans. Compare the advantages of all tables and you too, will demand only the Mont R. Reid.



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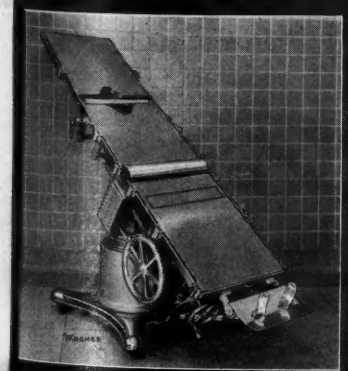

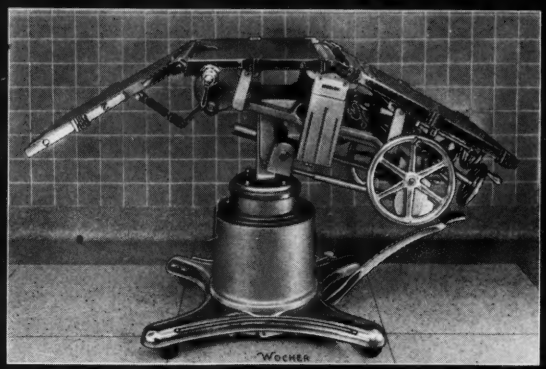

Clarence J. Cummings, President
Association of Western Hospitals

in the health and welfare of the community, perhaps to a greater extent than the hospitals in larger centers of population, its problems of standardization and organization are often complex and difficult to solve.

"The Spirit of Hospital Service," as presented on Tuesday morning of the convention, by the Rev. Paul R. Zwilling, was a most inspiring address. He gave a program of professional philosophy in its optimum form, against which as a standard, hospital people may measure their own concepts of professional philosophy. Though the professional philosophies of hospital people generally tend to be nebulous, it was anticipated that they will assume better form under effect of such an address as the Rev. Zwilling gave. Kindness, vision, balance, fervor—all these are elements of such philosophies, and we wish to learn the Spirit of Hospital Service, as it should be practiced for the good of the hospital and the good of the patient.

Glenn E. Myers, M.D., President
Association of California Hospitals

"Institutional Policies" as presented on Tuesday afternoon by Dr. Fred G. Carter, covered a valuable range of material which provoked much discussion. Doctor Carter not only dealt with coded policies, such as regulations and published rules, edicts of the administrator and resolutions of the directors, but dwelt principally upon the unwritten and oftentimes intangible policies which have to do with habits, traditions, customs and attitudes for the benefit of solving our various problems in connection with staff, employees, patients, visitors and other professional contacts.

The audience was greatly inspired by a talk at the Wednesday morning general assembly given by James A. Hamilton. Mr. Hamilton, in his usual forceful and humorous style, held his audience at close attention while he presented a marvelous address on "Building an Esprit de Corps," and pointed out to directors and administrators their responsibilities and duties in connection with the esprit de corps within their own hospitals.

Of no less interest was the address on "Building Good Will" which Doctor Benjamin W. Black, president-elect of the American Hospital Association, gave on Wednesday afternoon before a general assembly. Doctor Black brought home to us all the importance of building up good will both inside and outside of the hospital's walls.

The closing session on Thursday morning was given over to "Looking Into the Future," and three major topics of importance were presented, as follows: "The Hospital Plant," "Hospital Service Associations," and "Legislation." These were followed by valuable panel discussions.

All in all, it was one of those meetings on which one looks back with a sense of time well spent and useful knowledge acquired, and with pleasant memories of many friendly contacts.

The following officers were elected:

President—Clarence J. Cummings, Administrator, Tacoma General Hospital, Tacoma, Washington

President-Elect—Ellard L. Slack, Administrator, Samuel Merritt Hospital, Oakland, California

First Vice-President—Dale L. Smith, Superin-

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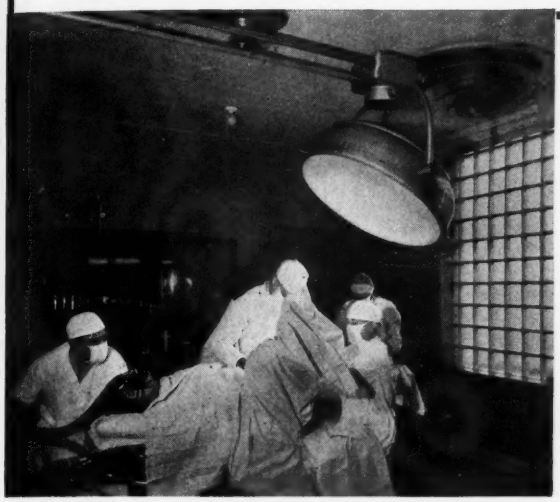

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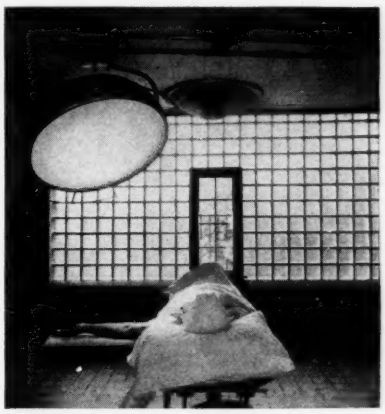

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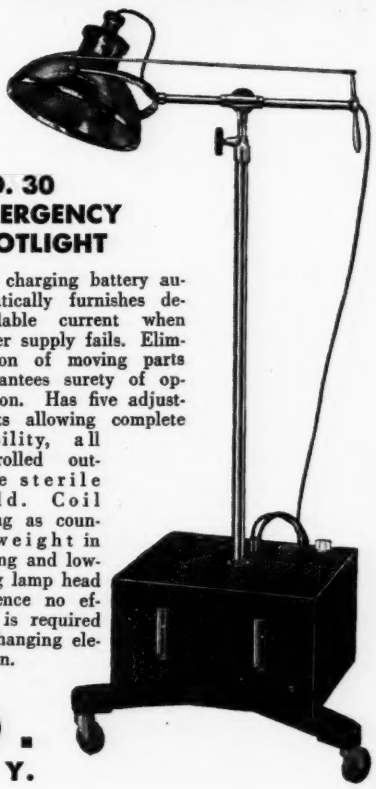

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Southeastern Hospital Conference

The Southeastern Hospital Conference, composed of the hospital representatives from Florida, Georgia, Alabama, Mississippi, Louisiana and Tennessee, met in their Fifth Annual Conference, together with the Southeastern Assembly of Nurse Anesthetists and the Mississippi Dietetic Association, at the Edgewater Gulf Hotel, Edgewater Park, Mississippi, March 28-30. The president of the Conference, Dr. A. M. McCarthy, Electric Mills, Mississippi, and the secretary of the Conference, Dr. Leon S. Lippincott, Vicksburg, Mississippi, arranged an excellent program, with the evenings given over to dinners, banquets, balls and other forms of relaxation and entertainment.

One of the features of the entertainment program was the plantation party given by the exhibitors on Thursday for the delegates of the Assembly and their friends.

The Assembly opened on March 28 with Dr. A. M. McCarthy presiding. After the invocation, addresses of welcome were delivered by Honorable Louis Braun, Mayor of Biloxi; Dr. Gilruth Darrington, Yazoo City, president of the Mississippi State Hospital Association; and Dr. J. P. Wall, Jackson, president of the Mississippi State Medical Association.

Mrs. H. O. Barker of Alexandria, president of the Louisiana Hospital Association, presided at the session at which the following subjects were presented:

The Small Hospital and Its Special Problems
Mrs. Jewell W. Thrasher, Dothan, Alabama

Minimum Standards for Small Hospitals
Dr. J. Gould Gardner, Columbia, Mississippi

Practical Business Methods in Dealing with Patients
Dr. A. J. Hockett, New Orleans, Louisiana

This Problem of Visitors
G. E. Mowry, Birmingham, Alabama

The round table at the close of this session was conducted by Graham L. Davis, Kellogg Foundation, Battle Creek, Michigan, and Dr. W. L. Shackelford, West Palm Beach, Florida.

At the Thursday afternoon session, J. H. Therrell, Chattahoochee, president of the Florida Hospital Association, presided. At this session the following subjects were presented:

Meeting Our Responsibilities as Members of the Medical Staff in Assuring Good Medical Records in the Hospital
Dr. Robert L. Sanders, Memphis, Tennessee

Should a Small Hospital Develop a Public Relations Program?
Alden B. Mills, Chicago

Meeting the Clinical Laboratory Problems of the Small Hospital
Dr. J. S. Tuberville, Century, Florida

National Hospital Day
Albert G. Hahn, Evansville, Indiana

The round table preceding the close of this meeting was led by James A. Hamilton, New Haven, Connecticut, president of the American College of Hospital Administrators, and Robert S. Hudgens, Atlanta, Georgia.

At the program of the General Assembly held on Friday, V. R. Bottomley, Greenville, Tennessee, president of the Tennessee Hospital Association, presided. At this session the reports on the program of hospital service plans in their states were read by the following:

Alabama—E. S. Moore, Birmingham
Florida—J. H. Holcombe, Jacksonville
Georgia—C. J. Anderson, Atlanta
Louisiana—Edward Groner, New Orleans
Mississippi—Dr. A. Street, Vicksburg
Tennessee—George W. Eutsler, Kingsport

Following these reports, Dr. E. R. Nobles gave a report on an experiment concerning a combined hospital and medical service plan. The round table discussion at this session was led by C. Rufus Rorem, director, Commission on Hospital Service, American Hospital Association, Chicago, and Graham L. Davis, Kellogg Foundation.

At the Conference Luncheon on Friday, Dr. Henry Heddon of Memphis, presided. The theme of this discussion was "The Educational Activities of the American College of Hospital Administrators," and the speakers were James A. Hamilton, Graham L. Davis, Dr. Bert W. Caldwell, executive secretary of the American Hospital Association, and Dr. Robin C. Buerki, director of the Study of the Commission on Graduate Medical Education, American Hospital Association.

At the Friday afternoon session Harry Smith, Columbus, president of the Georgia Hospital Association, presided, and the following subjects were presented:

Anesthesia Service in the Small Hospital
Mrs. Gertrude Fife, Cleveland, Ohio

Training Student Nurses in Dietetics
Miss Fairfax T. Proudfit, Memphis, Tennessee

Management of the Surgical Department
Lois Douglas, Atlanta, Georgia

The round table discussion following this session was led by Dr. Henry Heddon and W. D. Barker, Atlanta, Georgia.

At the Annual Banquet on Friday evening, Rev. Camille Estornelle, Ph.D., Rector of Holy Trinity Church, Vicksburg, Mississippi, was the toastmaster. The banquet speakers were Dr. J. P. Wall; Honorable Carl Marshall, Gulfport, Mississippi; Asa S. Bacon, Chicago; and Dr. Bert W. Caldwell.

At the Saturday morning session Clyde L. Sibley, Birmingham, president of the Alabama Hospital Association, presided, and the following subjects were presented:

The Use of Aptitude Tests in Selection of Hospital Personnel
James A. Hamilton, New Haven, Connecticut

Organization and Management of a Gas Therapy Department
Esther Myers, New Orleans, Louisiana

Hospital Accounting: Its Need and Value
Graham L. Davis, Battle Creek, Michigan

Control of Postoperative Infections in the Hospital
Dr. Wadley Glenn, Atlanta, Georgia

The round table following this session was led by Dr. A. J. Hockett and Dr. Eugene B. Elder, Chattanooga, Tennessee.

The recreation feature of the week was the Pageant Week Festivities arranged by the Seven Cities-By-The-Sea, the cities that joined one another along the Mississippi Gulf Coast. These included a historic pageant, a plantation dinner, folk dancing, a coastwide flower show, tours of old homes and gardens, and the annual golf tournament.

The technical exhibit at the Southeastern Hospital Conference was beautifully staged and very extensive. The exhibit filled the entire public space of the Edgewater Gulf Hotel, and practically all of the more important manufacturers and commercial firms dealing with the hospital field were represented.

The attendance at the Southeastern Conference was the largest in the five years of its history. More than five hundred people were registered representing three hundred fifty of the hospitals of the southeastern states.

At the annual business meeting, Dr. A. J. Hockett, superintendent of Touro Infirmary, was elected president of the Conference for the coming year, and Dr. Leon S. Lippincott was re-elected secretary. New Orleans was chosen as the meeting place for the 1941 convention.

Carolinas-Virginias Hospital Conference

The tenth annual meeting of the Carolinas-Virginias Hospital Conference, held this year in Winston-Salem, April 4 to 6, was generally acknowledged as one of the most successful ever held from the standpoint of interest, attendance, and congeniality. To a large extent this was due to the excellent cooperation of the Executive Committee, of which Dr. Vance P. Peery of Kinston was President and Sample B. Forbus of Durham was Secretary-Treasurer, and the Local Arrangements Committee of which Dr. J. B. Whittendon of Winston-Salem was Chairman.

The three morning sessions were devoted primarily to problems and procedures relating to group hospitalization, care of indigents, dietetics, and medical records. The afternoon sessions were devoted to nursing practice, particularly as it relates to hours, education, and the student nurse; to industrial compensation; to diagnostic service in small hospitals; and to the place of the medical social worker in the hospital. Two special luncheon meetings were covered by talks on "Hospital Standards and How to Maintain Them," and "The Place of the Voluntary Hospital in the Federal Health Program."

The social amenities were more than adequately cared for at the Conference. On Thursday evening there was a most delightful "Presidents' Buffet Supper" and an "Exhibitors' Dance," and on Friday there was the "Annual Banquet" which provided, in addition to the amusement and stimulus of more than one hundred prizes furnished by the local merchants and a most entertaining floor show, a congenial and pleasant dance at which members renewed acquaintances and entertained guests.

The newly elected officers of the four state associations are as follows:

North Carolina Hospital Association: President, Fred C. Hubbard, M.D., Wilkes Hospital, North Wilkesboro; President-Elect, J. Lyman Melvin, Park View Hospital, Rocky Mount; Secretary-Treasurer, Sample B. Forbus, Watts Hospital, Durham. The newly elected Trustees of this Association are Vance P. Peery, M.D., Memorial General Hospital, Kinston, and Harry L. Brockman, M.D., High Point.

Virginia Hospital Association: President, W. N. Walter, Lewis-Gale Hospital, Roanoke; Vice-

President, Arthur H. Perkins, M.D., Norfolk General Hospital, Norfolk; Secretary, M. Haskins Coleman, Jr., Richmond Hospital Service Association, Richmond; Treasurer, W. L. Beale, Medical College of Virginia, Hospital Division, Richmond. The Trustees are the officers with Lewis E. Jarrett, M.D., Medical College of Virginia, Hospital Division, Richmond; Lillian E. Jerdone, R.N., Pulaski Hospital, Pulaski; O. K. Fike, Grace Hospital, Richmond; Stuart G. Aldhizer, Rockingham Memorial Hospital, Harrisonburg; and Harriet V. Ailstock, Parrish Memorial Hospital, Portsmouth.

South Carolina Hospital Association: President, Mrs. Byrd B. Holmes, R.N., Greenville General Hospital, Greenville; President-Elect, James L. Rogers, Spartanburg General Hospital, Spartanburg; Vice-President, R. C. O'Brien, St. Philip's Mercy Hospital, Rock Hill; Second Vice-President, H. H. McGill, Columbia Hospital of Richmond County, Columbia; and Treasurer, Charles H. Dabbs, Tuomey Hospital, Sumter. The Secretary is to be appointed by the Board of Trustees.

Hospital Association of West Virginia: President, T. L. Harris, M.D., St. Joseph Hospital, Parkersburg; President-Elect, H. C. Myers, M.D., Myers Clinic, Philippi; Vice-President, Dean L. Hosmer, M.D., Bluefield Sanitarium, Bluefield; Secretary-Treasurer, Charles F. Runyon, M.D., Charleston General Hospital, Charleston. The newly elected Trustees of this Association are R. O. Rogers, Bluefield Sanitarium, Bluefield, and J. Stanley Turk, Ohio Valley General Hospital, Wheeling.

The Mid-West Hospital Association Convention

When the fourteenth annual convention of the Mid-West Hospital Association, held at Hotel Continental, Kansas City, Missouri, April 11 and 12, 1940, closed with an all high record in point of attendance, quality of program, and enthusiasm on the part of both members and exhibitors, the officers and trustees of the organization agreed that it pays to advertise. It was voted last year to concentrate on advance publicity and, as a result, beginning last November, a monthly pictorial letter was sent to every member in the five states. In addition, each board member in the five-state area received three letters emphasizing the importance not only of his attendance but also of insisting upon his hospital administrator attending and a last-minute special invitation to the Hospital Trustees Luncheon was mailed the board members of all hospitals within a 100-mile radius of Kansas City. When all former attendance records were broken, the officers felt that the inroad on the treasury for postage had been a good investment.

The meeting was called to order at 10 a. m. by John O. Steel, president of the Mid-West Hospital Association and superintendent of Davis Hospital, Pine Bluff, Arkansas. Following the invocation by Reverend Father Anthony Jung, pastor of the Lady of Perpetual Help Church, Kansas City, Paul E. Robinson, president of the Missouri Hospital Association and the Kansas City Council of Hospitals and superintendent of Neurological Hospital, Kansas City, gave what he had predicted would be the shortest address of welcome on record.

Henrietta Froehlke, R.N., director of the University of Kansas School of Nursing, the University of Kansas, University of Kansas Hospitals, Kansas City, Kansas, gave an excellent paper on "The Accrediting Program of the National League of Nursing Education," which provoked a great deal of argument, especially from superintendents of the smaller hospitals, who voiced their approval of the theory but raised the question of the hospitals' inability to meet the requirements. One point raised was the unwillingness of well qualified nurses from the larger schools to go to the small hospitals.

Geraldine R. Lermit, dean of the St. Louis School of Occupational and Recreational Therapy, St. Louis, spoke on "Educational Trends in the Field of Occupational Therapy," commenting on the advancement made since physicians have come to appreciate its value and administrators have realized that including it in the hospital budget is worth while. An innovation of the morning program was the interjection of a short musical program. Noting the pleasant effect this interlude had upon the audience, Miss Lermit used it as an example of the value of music therapy which the public has been slow to recognize.

"The Role of the Hospital in Graduate Medical Education" was presented by Dr. Robin C. Buerki, director of study, Commission on Graduate Medical Education, Chicago, who reminded us that hospitals with a good intern service usually increase their bed occupancy. He urged that hospitals, in consideration of the fact that there are at present 1400 more internships than interns to fill them, not create more intern positions but concentrate on improving the positions now available. He asked us to remember that the internship should not be considered a repetition of medical school work; instead the intern should round out his undergraduate period, and to do this he must have time to think, read, and cultivate study and reading habits. He admonished us not to lose sight of the fact that the intern in our hos-

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pital today may, for the next thirty years, be the practicing physician on our hospital staff and impressed upon us the necessity of so training the men during their internship that they will return as staff members whom we will welcome.

The trustees' luncheon has become one of the high-lights of the Med-West Hospital Association's annual meeting. As the hospital trustee is, or should be, keenly interested in legislation affecting the hospital field, Dr. Bert W. Caldwell, executive secretary of the American Hospital Association, Chicago, and Alden B. Mills, Chicago, were invited to speak on this subject and President Roosevelt's plan to provide small hospitals in rural communities that are at present without hospital facilities.

More than a hundred guests were present at this luncheon, to which were invited the members of the boards of trustees of all the local and nearby hospitals. Frank J. Walter, superintendent, St. Luke's Hospital, Denver, presided, commenting as he introduced the guest speakers, that the Mid-West was determined that no longer could it be said that the hospital trustee is the forgotten man.

At the afternoon session, of which Dr. A. R. Hatcher, superintendent of Hatcher Hospital Clinic, Wellington, Kansas, presided, Edith Marcum, R.N., chief anesthetist, Jewish hospital, St. Louis, gave a paper, "Telling the Public," stressing the need for a better appreciation of the field of anesthesia on the part of the public. She emphasized the value of having the hospital administrator acquaint the public with the whys and wherefores of anesthesia charges, the safety precautions taken, and the need for well trained anesthetists.

Lewis Kitchen, of Lewis Kitchen Realty Company, Kansas City, gave an excellent talk on building maintenance from an office building manager's point of view and presented mimeographed charts showing his method of keeping a record of repairs, wall and window washing, etc.

"Legal Problems of the Hospital Administrator" was then presented by Henry H. Caldwell, a member of the Chicago Bar, who stressed the fact that no longer are hospitals receiving blanket indemnity from all legal responsibility because of their being charitable institutions. He emphasized the fact that the hospital, whether it offers a charity service or not, is responsible for accidents to visitors who do not benefit from the hospital's charity. The visitor is a stranger within its gates and is not a beneficiary of any charity it may dispense. Therefore, in the majority of states the law allows recovery in these cases so it is particularly important that the hospital not overlook its responsibility as regards the lighting of stairs and hallways and the safe operation of its elevators. He cautioned us about the wisdom of immediately reporting all accidents to visitors and employees to the insurance company, procuring the names of witnesses, instructing employees not to discuss the case with anybody and having the patient sign a statement at the time of the accident. He emphasized the ultimate economy of hospitals having ample and well planned insurance programs, stating that adequate insurance coverage will save the hospital many times the cost of the premiums and the hospital will be relieved of responsibility for defending the case, retaining legal counsel, paying witness fees and spending time in courts. Mr. Caldwell urged particularly that hospitals keep their insurance up to date so that it will cover the new equipment that is constantly being added. A timely reminder concluded Mr. Caldwell's remarks—that more and more is it being proven that fatigue is a major factor in many accidents and that the hospital is responsible for the fatigue of its nurses.

At the banquet at 7 p. m., at which John O. Steel presided, Tom Collins, assistant to the publisher of the Kansas City Journal, Kansas City, gave a delightful, humorous talk, following which Dr. Rex L. Diveley, Kansas City, showed beautiful colored movies which he had taken during an 18,000 mile aerial trip through South America. Instrumental music was furnished by the Strolling Trio and vocal selections were rendered by Ina P. Hattey of Independence, Missouri, and Frederick E. Oliver of Lamoni, Iowa.

At the Friday morning session, presided over by H. A. Black, superintendent of Parkview Hospital, Pueblo, Colorado, the first part of the meeting was given over to a panel discussion of nonprofit voluntary service plans, conducted by Ray F. McCarthy, executive director of Group Hospital Service, St. Louis. Those participating in the discussion were: Reverend O. J. Carder, superintendent, Missouri Methodist Hospital, St. Joseph, Missouri; L. C. Austin, superintendent, Menorah Hospital, Kansas City, Missouri; Msgr. John R. Mulroy, president, Colorado Hospital Service Association, Denver; Dr. Raymond T. Smith, president, Arkansas Hospital Association; Sparks Memorial Hospital, Fort Smith, Arkansas; William S. McNary, executive director, Colorado Hospital Service Association, Denver; Maurice J. Norby, director of Research Program—Council on Hospital Service Plans, American Hospital Association, Chicago; and Earl R. Sweet, executive director, Group Hospital Service, Kansas City.

James A. Hamilton, director of the New Haven

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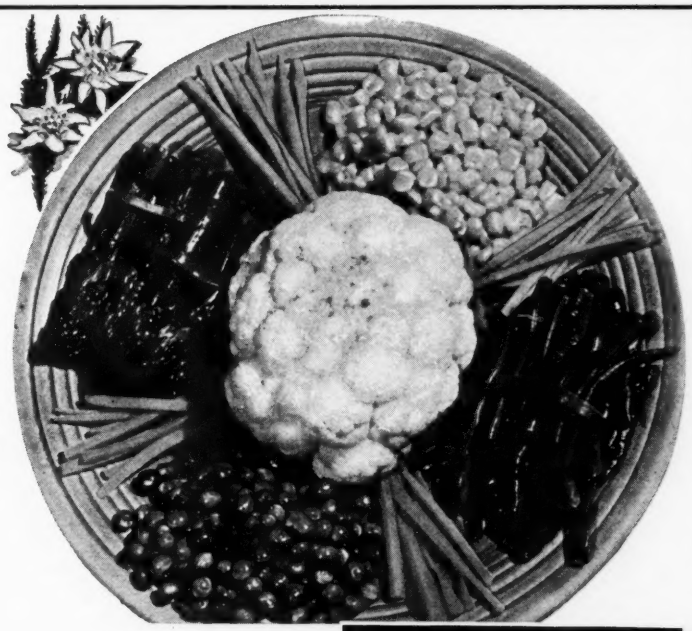

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Hospital, New Haven, Connecticut, and president of the American College of Hospital Administrators, then spoke on "Personnel Management," urging that hospital administrators not lose sight of the fact that their employees are human beings who, if given an opportunity, will develop as much pride and interest in the institution as the administrator and president of the staff.

At the annual luncheon business meeting the following officers were elected:

President-Elect—E. E. King, Superintendent, Missouri Baptist Hospital, St. Louis, Missouri

First Vice-President—Rev. J. E. Lander, Superintendent, Wesley Hospital, Wichita, Kansas

Second Vice-President—Regina H. Kaplan, Superintendent, Leo N. Levi Memorial Hospital, Hot Springs, Arkansas

Trustees—Terms expire 1943

John O. Steel, Superintendent, Davis Hospital, Pine Bluff, Arkansas
(replacing Lee C. Gammill)

Msgr. John R. Mulroy, President, Colorado Hospital Service Association; Diocesan Director, Catholic Charities, Denver; Vice-President, American Hospital Association
(replacing William S. McNary)

Dorothy McMasters, Superintendent, William Newton Memorial Hospital, Winfield, Kansas; Secretary, Kansas Hospital Association
(replacing Rev. J. E. Lander)

Laura A. Hornback, Superintendent, Pike County Hospital, Louisiana, Missouri
(replacing Elmer Ahlstedt)

Mrs. D. I. Browne McNulty, Superintendent, Morningside Hospital, Tulsa, Oklahoma
(replacing Florence Worley)

Florence King, Administrator, Jewish Hospital, St. Louis, was reappointed Executive Secretary and Treasurer.

Dr. E. T. Olsen, medical director and assistant superintendent of the State University and Crippled Children's Hospitals, Oklahoma City, Oklahoma, presiding at the Friday afternoon session, introduced Katherine Maris, dietitian at St. Luke's Hospital, Kansas City, who discussed "Food Problems in Pleasing the Patient." Mr. Hamilton then spoke on "Activities of the American College of Hospital Administrators," and the balance of the afternoon was given over to an excellent round-table discussion conducted by Mr. Hamilton.

An important feature of the meeting was a decision of the trustees of the Mid-West Hospital Association to hold all subsequent meetings in Kansas City, as it seems the ideal location for members of the five states.

The high-light of the meeting was the organization of the Mid-West Assembly of Nurse Anesthetists composed of the anesthetists from the five member states, which organization will meet annually with the Mid-West Hospital Association. Much credit is due Jessie Lindsey, president of the Missouri Association of Nurse Anesthetists, who took the initiative in inviting the anesthetists of Missouri and the other four states to attend a conference in conjunction with the Mid-West Hospital Association meeting. Then, with the assistance of Rosalie McDonald, chief anesthetist, Emory University Hospital, Atlanta, Georgia, and Miriam G. Shupp, president of the American Association of Nurse Anesthetists and chief anesthetist of Strong Memorial Hospital, Rochester, New York, organization plans were adopted and the following officers elected:

President—Ann Cox, Missouri Baptist Hospital, St. Louis.

Secretary-Treasurer—Edith Marcum, Chief Anesthetist, Jewish Hospital, St. Louis.

Convention of the Ohio Hospital Association

The Twenty-Sixth Annual Convention of the Ohio Hospital Association officially opened with a luncheon on Tuesday noon, April 2, 1940, at the Deshler-Wallick Hotel in Columbus, Ohio. Mayor Floyd F. Green of Columbus welcomed the members, after which representatives of eighteen different departments of the State of Ohio, with whom hospitals transact business, were introduced to members of the Association.

Forty-one exhibitors were represented at the Convention, the largest number in the history of the Association. The exhibitors gave a dance on Tuesday evening to members, which was well attended by hospital people.

A sectional meeting for members of board of trustees of hospitals was conducted under the leadership of Dr. F. G. Carter, president of the American Hospital Association, Chairman; Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, and Dr. Robin C. Buerki, director of study, Commission on Graduate Medical Education. Dr. Buerki spoke on the subject, "The Relationship of the Board of Trustees to the Medical Staff." Dr. Doane spoke on the subject, "The Crux of a Good Hospital." This meeting was attended by 55 trustees of Ohio hospitals, and

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was considered by the trustees to be of sufficient value to repeat during the year.

There are seven affiliated associations in Ohio meeting annually at the same time. This year a panel discussion was developed by the affiliated associations with the central theme of "Administrative Practice." Dr. Robin C. Buerki of Chicago was coordinator for these groups.

The directors of the Hospital Service Corporations in Ohio planned the most successful last day meeting of the Association held in years. John R. Mannix, director of the Michigan Plan, spoke on the "Relationship Between Hospital Service Plans and Hospitals"; John A. McNamara, director of the Cleveland Plan, covered the subject of cooperating hospital members; Robert E. Mills, Director of the Youngstown Plan, reported on the operation of the new enabling legislation; Michael A. Kelly, associate director of the Cleveland Plan, reported on the "Social Aspects of Hospital Service Plans."

A record has been established in Ohio in the matter of always having the Governor of Ohio present at the banquet. Governor Bricker cooperated in maintaining this record by excusing himself from a political rally long enough to greet our members. Mayor Harold Burton of Cleveland also dropped in on the banquet for a few moments.

The Constitution and By-Laws of the Association were amended so as to make permanent the Council on Hospital Service Plans. This Council will be composed of four hospital administrators, and two service plan directors. The Amendment also included the permanent establishment of an Advisory Committee to the Council to be composed of the directors of approved plans.

Guy J. Clark of Cleveland, and Dr. M. F. Steele of Cincinnati were elected delegates to the American Hospital Association, House of Delegates. Mabel F. Pittman of Findlay, and Harry H. Graef of Akron were elected alternates.

The officers for the ensuing year are:

President—Dr. Frank G. Fowler, Columbus

President-Elect—Worth L. Howard, Akron

Vice-President—Winifred Culbertson, Cincinnati

Second Vice-President—Sister M. Carmeletia, Cleveland

Treasurer—Rt. Rev. Msgr. M. F. Griffin, Cleveland

President Northeastern District Council—Dr. R. H. Bishop, Cleveland

President Northwestern District Council—W. L. Benfer, Toledo

President Southwestern District Council—Francis Van Buren, Cincinnati

President Central District Council—Ruth Brant, Martins Ferry

New Jersey State Hospital Association

The New Jersey State Hospital Association held its recent meeting at the Children's Country Home, Westfield, New Jersey, April 26.

The address of welcome was given by Mrs. Harry A. Kniffen, president of the Board of Managers, Children's Country Home, and the business session was presided over by Mrs. Mary Stone Conklin, president of the New Jersey Hospital Association. The speakers were Cora E. Gould, superintendent of Children's Country Home; Dr. Emil Frankel, director, Division of Statistics and Research of the State of New Jersey, Trenton; and Reverend John G. Martin, superintendent of Hospital of St. Barnabas and for Women and Children, Newark.

Nebraska Hospital Assembly

The Fourth Nebraska Hospital Assembly, which was held at Lincoln, Nebraska, March 27, was considered the most successful of any held. There were a total of 31 hospitals represented and a total attendance of approximately 150. Meeting with the hospital executives were the dietitians, pharmacists, and the technicians.

Outstanding in the day's program was an address at the noon luncheon by Professor Zoph of the University of Iowa, on "Changing Trends in Pharmaceutical Service." The address was received with considerable enthusiasm by all those present and marked a departure from the usual custom by the choice of a speaker from one of the allied groups.

The only formal action of note taken by the Assembly was the approval by the Assembly of the experimental conduction of a new type of community training school for bed-side nursing. This action resulted following a panel discussion of the nursing problem led by Ursula Penner. In spite of some opposition voiced by the graduate nurses present, it was felt that many of the small hospitals of Nebraska were unable economically to meet the financial burden of having graduate nurses entirely staff their hospitals. The new type of school for training community nurses contemplates a two-year course and is in effect al-

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ready in operation at the Mennonite Deaconess Hospital in Beatrice.

The retiring president, Mrs. Gladys Smits, gave an excellent summary of the problems confronting hospitals today, stressing the necessity of cooperation of all hospitals in their attention to national problems.

Considerable time was given to a discussion of a hospital survey of the state, with an attempt to more sharply define the standards for membership in the assembly.

The following officers were elected:

President: Dr. C. A. Lutgen, Auburn Hospital, Auburn.

President-elect: Ursula Penner, Mennonite Deaconess Hospital, Beatrice.

Secretary-Treasurer: Dr. F. J. Bean, University Hospital, Omaha.

Board of Directors for four years: Margaret Grandy, Brodstone Memorial Hospital, Superior.

Board of Directors for two years: Mrs. Gladys Smits, Lincoln General Hospital, Lincoln.

Tennessee Hospital Association Meeting

The annual meeting of the Tennessee Hospital Association was held at the Patten Hotel in Chattanooga on April 8, immediately prior to the opening session of the annual meeting of the Tennessee State Medical Association.

The reports of President V. R. Bottomley of Greeneville and Secretary-Treasurer T. H. Haynes of Knoxville were followed by an address by Arnold F. Emch, Ph.D., Assistant Secretary of the American Hospital Association, on "Federal Health Legislation and Its Relation to Hospitals."

Other speakers were Dr. Fred Strain, Tennessee Valley Authority, whose subject was "The Hospital and Public Health," and Nina E. Wootton, Secretary of the Tennessee Committee on Nursing Education and Nursing Practice, who spoke on "Minimum Standards in Schools of Nursing in Tennessee." Elizabeth Sloo of the Nashville Protestant Hospital spoke on "National Hospital Day."

At noon the visitors were luncheon guests at the Pine Breeze Sanatorium where the afternoon session was held. Dr. W. W. Hubbard, director of the Tuberculosis Hospitalization Service in Franklin, spoke on "The Role of General Hospitals in a Tennessee Tuberculosis Control Program." A discussion on this topic was then led by Dr. Horton Casparis of the Department of Pediatrics of Vanderbilt University Hospital in Nashville.

Dr. R. L. Sanders of Memphis also spoke at the afternoon session on "Functions of Medical Staff in the Hospitals." Another afternoon speaker was S. S. McCrary, Jr., whose topic was "Trend in Group Hospitalization."

Charles A. Noone, a prominent Chattanooga attorney, delivered the address at the annual banquet that evening.

The newly elected officers are: President, T. H. Hayes, General Hospital, Knoxville; President-elect, R. G. Ramsay, Gartly-Ramsay Hospital, Memphis; Vice-President, Elizabeth Sloo, Protestant Hospital, Nashville; Secretary-Treasurer, H. L. Maloney, Fort Sanders Hospital, Knoxville.

Coming Meetings

Tri-State Hospital Assembly (Illinois, Indiana, Wisconsin and Michigan), Chicago, May 1-3

Hospital Association of Pennsylvania, Pittsburgh, May 8-10

Kansas Hospital Association, Wichita, May 16-17

Washington State Hospital Association, Spokane, May 18

Connecticut Hospital Association, New Haven, May 22

Hospital Association of the State of New York, Buffalo, May 22-24

Minnesota Hospital Association, Minneapolis, May 23-25

South Dakota Hospital Association, Sioux Falls, May

New Brunswick Hospital Association, St. Stephen, N. B., June 6

New Jersey Hospital Association, Atlantic City, June 6-8

Catholic Hospital Association, St. Louis, Missouri, June 17-21

Hospital Association of Nova Scotia and Prince Edward Island, Bridgewater, N. S., June

Idaho Hospital Association, Boise, July 15

National Hospital Association, Houston, Texas, August 11-13

American Protestant Hospital Association, Boston, September 13-15

American College of Hospital Administrators, Boston, September 14-16

American Hospital Association, Boston, September 16-20

American Association of Nurse Anesthetists, Boston, September 16-20

Maine Hospital Association, Lakewood, September

American Dietetic Association, New York City, October 20-24

Alberta Hospital Association, Calgary, October

Ontario Hospital Association, Toronto, October

Vermont Hospital Association, Montpelier, October

Saskatchewan Hospital Association, Regina, October

Colorado Hospital Association, Denver, November 13

Oklahoma State Hospital Association, Oklahoma City, November 16-17

Utah State Hospital Association, Salt Lake City, December 5

1941

Texas Hospital Association, Galveston, February 27, 28, and March 1

SILVER ANNIVERSARY GREETINGS

THE Catholic Hospital Association next month marks its Silver Anniversary, enters into its second quarter-century of eminently successful hospital service.

To this group of unselfish workers, the Hospital Industries Association extends its sincere congratulations, pledges its continued cooperation, voices confident good wishes for the Catholic Hospital Association's success in the years ahead.

Hospital Associations in the United States and Canada provide the chief means for hospitals to develop group solidarity, benefit as a group from the experience of each individual. Association influences are at work every day in the year to raise the standards of hospital administration and nursing technic.

Similarly, the Hospital Industries Association attempts sincerely to raise the standards of business relations between hospitals and their suppliers.

To all Hospital Associations, national and sectional, the Hospital Industries Association pledges its continued cooperation in working toward the common goal of even better hospital service for the sick.

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Wilson Rubber Company Canton, Ohio
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News of Interest to the Hospital Field

Mrs. E. C. Bernhard has succeeded **Katherine Brown, R.N.,** as superintendent of Jeanes Hospital, Philadelphia, Pennsylvania. Mrs. Bernhard was formerly assistant superintendent of Welfare Island City Home, New York City.

Louis B. Blair, who has been credit manager and social investigator in Cincinnati General Hospital, Cincinnati, Ohio, for the past five years, has been appointed business administrator of the Ironton General Hospital, Ironton, Ohio. **Miss Brown** will continue as superintendent of the hospital, actively in charge of hospital operation and activities.

Maurice L. Brittle has resigned as superintendent of the Milford Town Infirmary, Milford, Massachusetts.

Frederic W. Brouitt has been appointed executive manager of the Chippewa County War Memorial Hospital at Sault Ste. Marie, Michigan. **Mrs. Janet Larson,** who has been acting superintendent since Emma B. Dickison resigned as superintendent, has been appointed superintendent of nurses.

Dr. Madison B. Brown has accepted the position of assistant director of the Roosevelt Hospital, New York City, effective May 1.

Dr. Charles L. Clay, formerly medical director of Long Island Hospital, Boston, Massachusetts, has accepted the superintendency of the Jackson Memorial Hospital, Miami, Florida, effective May 1.

General Wallace DeWitt, commander general of the Army Medical Center, Washington, D. C., has been appointed officer in charge of the Letterman General Hospital, San Francisco, California.

Kathreen M. Duffy, R.N., succeeds **Hazel M. Gosnell, R.N.,** as superintendent of the Albert Lindley Lee Memorial Hospital, Fulton, New York. Miss Duffy, formerly director of nurses of this institution, has been acting superintendent since Miss Gosnell's resignation on February 1.

Nellie K. Ferguson has been acting superintendent of the Meriden Hospital, Meriden, Connecticut, since the death of **Mary E. McIntyre.**

Bertie Gardner, R.N., has succeeded **Evelyn M. Heath, R.N.,** as superintendent of the Northampton-Accomac Memorial Hospital, Nassawadox, Virginia.

Mrs. Florence C. Gorman has assumed the superintendency of the Collins Memorial Hospital, Knoxville, Iowa, which was opened recently.

Frances Hopper, assistant superintendent of the Armstrong County Hospital, Kittanning, Pennsylvania, has been named acting superintendent of that institution, following the resignation of **Charlotte W. Ager** as superintendent.

Sister M. Josephine, Superior of the medical floor in St. Elizabeth's Hospital, Chicago, was named Superior of St. Catherine's Hospital, East Chicago, Indiana, succeeding **Sister Mary Virgilia,** who served as superintendent of St. Catherine's for six years.

James H. Lewis assumed his duties as superintendent of the Community Hospital, Newark, New Jersey, on November 1, 1939. Mr. Lewis was formerly cashier and bookkeeper of the Burrell Memorial Hospital, Roanoke, Virginia. Mr. Lewis succeeded **Dr. John A. Kenney,** who resigned as medical director of Community Hospital to become medical director of the John A. Andrew Hospital, Tuskegee Institute, Tuskegee, Alabama.

Dr. Karl Morgan Lippert has resigned as director of the Chatham Hospital, Silver City, North Carolina.

Ruth Mahan, R.N., was recently appointed superintendent of the Lindsey-Johnson-Shirley Hospital, Pauls Valley, Oklahoma.

Rev. Omer B. Maphis, who for the past several years has been superintendent of the Bethany Sanitarium and Hospital, Chicago, has resigned to accept a position with the Publishing Department of the Brethren Publishing House, Elgin, Illinois.

Mabel Merrick, R.N., has assumed her duties as administrator of Tuxedo Memorial Hospital, Tuxedo Park, New York.

J. W. Mirfield has been named business manager of the J. C. Hammond Hospital, Geneseo, Illinois.

Dr. Charles E. Remy has resigned as superin-

CLASSIFIED ADVERTISEMENTS

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Commercial announcements accepted at the same rate. Remittance must accompany classified advertisements.

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EDUCATION: (a) *Educational Director;* to be responsible for planning and execution of post-graduate and affiliate courses in Communicable Disease Nursing; large contagious hospital; $150, maintenance. No. 09906. (b) *Science Instructor;* large Eastern hospital with school of 118 students; fine reputation. No. 40-730. (c) *Nursing Arts;* 150-bed hospital; Western Mountain area; progressive school. No. 40-811.

SUPERVISION: (a) *Operating Room;* 300-bed hospital; West; teaching and administrative position; very active service; $125-$150, partial maintenance. No. 09709. (b) *Pediatrics;* 250-bed children's hospital; Middlewest; open August 1, 1940; supervision of 30-bed active Medical division, 35-bed cardiac division and 21-bed communicable disease unit; $110, maintenance; No. 40-786. (c) *Obstetrics;* 304-bed hospital; Middlewest; active service; available June 1, 1940; $110, maintenance. No. 40-711.

LABORATORY & X-RAY TECHNICIAN: 85-bed hospital; East; $80, maintenance. No. 09890.

ANESTHETIST: 100-bed hospital; South; qualified to administer all types of anesthesia; $125, maintenance. No. 09975.

STAFF NURSES (general duty); 192-bed hospital; Middlewest; $70, maintenance. No. 40-822. Many staff positions available; variety of fields; all localities; $60-$100, maintenance; 48-hour week.

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tendent of the Knickerbocker Hospital, New York City, effective May 1.

Mrs. Myrtle Santa Cruz succeeds **Mrs. C. Shievers** as superintendent of the King's Daughters Hospital, Gulfport, Mississippi.

Inga Sorvik, R.N., has resigned as superintendent of St. Luke's Hospital, Seattle, Washington, and **Helen Andrews** has been named as her successor.

Dr. Robert A. Staff has succeeded **Dr. Jerome V. Pace** as superintendent of the Indiana State Tuberculosis Sanatorium at Rockville, Indiana. Dr. Pace resigned to accept the position as head of the new Silvercrest Tuberculosis Hospital, New Albany, Indiana.

Mrs. Marie Sullivan has assumed her duties as superintendent of the DeQueen General Hospital, (formerly Childress Hospital), DeQueen, Arkansas.

Dr. Howard A. Welcher has resigned as medical director of Union City General Hospital, Union City, New Jersey, and **Dr. Walter H. Stubenrauch** has been named as his successor.

Opelika, Alabama—Under the terms of the will of Miss Margie McBurney, St. Mary's Mission House, Catholic institution of Opelika, was bequeathed a plot of nine acres and $10,000 on the condition the Mission build and maintain a hospital in which at least one charity ward must be provided.

Homestead, Florida—The new Municipal Hospital at Homestead, Florida, which will cost $36,000, is now nearing completion.

Knoxville, Iowa—The new Collins Memorial Hospital, Knoxville, Iowa, has been completed and is now ready for occupancy.

Washington, Iowa—Election will be held early in June on a bond issue of $50,000 to construct a new three-story addition to the Washington County Hospital, Washington, Iowa.

Lexington, Kentucky—The new $100,000 addition to St. Joseph's Hospital, Lexington, Kentucky, is now ready for occupancy.

Lexington, Kentucky—Contract for the construction of new facilities at the United States Public Health Service Hospital at Lexington, Kentucky, has been let. A new women's building, nurses' home, east wing to the main building, junior and senior medical officers' quarters, and a dining and recreation room will be constructed.

Mount Pleasant, Michigan—Citizens of Mount Pleasant, Michigan, and vicinity have arranged the necessary bond to secure a community hospital, sponsored by the Commonwealth Fund. The new institution will be of fifty-bed capacity.

Poplar Bluff, Missouri—Dr. H. M. Hendrickson, owner of Poplar Bluff Hospital, Poplar Bluff, Missouri, has announced a building program for his hospital which will include the construction of a new addition, increasing the capacity of the hospital to fifty-eight beds.

Rochester, New Hampshire—Citizens of Strafford County have raised $40,000 to be applied to the building and equipping of a new Frisbie Memorial Hospital in Rochester, New Hampshire, supplementing the $200,000 endowment gift made by the Spaulding family for this purpose.

Atlantic City, New Jersey—Contracts for the construction of a new fireproof one-hundred room tuberculosis hospital at Pine Rest and a fifty-room addition to the County Asylum, involving a total expenditure of $392,000, was formally awarded on April 10.

Camden, New Jersey—The Campbell Soup Company has given $320,000 for the construction of a new wing to the Cooper Hospital, Camden, New Jersey. The new wing is to be known as the John Thompson Dorrance Memorial, in memory of the late Dr. John T. Dorrance. The architectural drawings have been prepared, providing for a six-story unit, fireproof and modern in every detail. Construction will start as soon as the hospital board approves of the plans.

Elizabeth, New Jersey—Construction of a sixty-six bed addition to Bonnie Burn Sanatorium, Elizabeth, New Jersey, at an estimated cost of $100,000, was authorized by the Union County Board of Freeholders. Leslie M. Dennis of Elizabeth is the architect.

Binghamton, New York—The new six-story addition to the Binghamton City Hospital, Binghamton, New York, was opened for public inspection on April 3. At the completion of this new wing the Binghamton City Hospital will be the largest hospital in New York State except for certain hospitals located in New York City and Buffalo. The addition will contain 115 beds, and with the opening of the new unit, which cost $450,000, the capacity of the hospital will be increased to 550 beds.

White Plains, New York—The Westchester Division of New York Hospital at White Plains, New York, has started construction on a new $200,000 building, which will be completed within six months. The building will provide twenty beds for some mental patients who are acutely ill.

POSITIONS OPEN—(Continued)

NEW YORK MEDICAL EXCHANGE (Agency)
Patricia Edgerly, Owner and Director
489 Fifth Avenue
New York City

WE DO NOT CHARGE A REGISTRATION FEE

SUPERINTENDENT: (a) 200-bed hospital, metropolitan area. No training school. Salary open. (b) Small hospital, New England. Registered nurse preferred. Salary $1,800 to $2,500. (c) Small hospital, Pennsylvania. All graduate staff. Pennsylvania R. N. Salary open. (d) Man. 250-bed hospital. Metropolitan area. Hebrew. Salary $4,000 to $5,000, house and maintenance.

SUPERINTENDENT OF NURSES: (a) 125-bed hospital. N. Y. R. N. Training school experience. Salary $165 and maintenance. (b) Large New England hospital. University connections. Training school experience necessary. Salary open. (c) 200-bed hospital, Eastern seaboard. 100 students. Good experience. Salary open. (d) 100-bed hospital. Upstate New York. Training school. Degree. Salary, $150 and meals. (e) 250-bed southern hospital. Large training school. Good experience necessary. Salary $200 and maintenance. (f) Small hospital New England. Salary $125 and maintenance.

EDUCATIONAL DIRECTOR: 200-bed eastern hospital. Large training school. Salary open.

INSTRUCTORS: Many good openings in eastern hospital for September appointments. Degree and experience necessary. Salary $100 and maintenance up.

FOREIGN: General duty, speak Spanish fluently. Salary $125 and maintenance and transportation.

NURSE LABORATORY AND X-RAY: Eastern appointments. Salary $100 to $125.

ZINSER PERSONNEL SERVICE
1551 Marquette Building
Chicago, Illinois

NURSES, TECHNICIANS, DIETITIANS, PHYSICIANS, SUPERINTENDENTS—Let us help you secure a position!

POSITIONS OPEN—(Continued)

THE MEDICAL BUREAU
M. Burneice Larson, Director
Palmolive Building
Chicago, Illinois

WANTED—(a) Experienced administrator—lay or medical—for superintendency 500-bed general hospital nearing completion. (b) Assistant superintendent; county hospital system embracing four units. (c) Medical director; 1,000-bed institution; purely administrative appointments; $4,500, large home, completely furnished with service; complete family maintenance. (d) Young physician to assist medical administrator planning early retirement; previous administrative experience unnecessary; better than average medical training required. (e) Medical director, comparatively new tuberculosis sanatorium, county-owned; midwest. No. 730.

ADMINISTRATOR—For memorial hospital now in process of building; must be thoroughly experienced, capable advising on purchases of equipment, selection of personnel; highly cooperative Board. No. 731.

SUPERINTENDENTS OF NURSES—(a) Experienced nurse-executive, 30-40, to assume responsibility for school of nursing and nursing service; 250-bed hospital; degree required; pleasant living accommodations; vicinity New York City. (b) For 500-bed hospital, beautifully located in southwestern metropolis; training school averages 165 students. No. 732.

PRINCIPAL—Of nursing school; large student enrollment; degree and extensive experience essential; $3,000, maintenance. No. 733.

FACULTY APPOINTMENTS—(a) Instructor, pediatric nursing; duties will include assisting principal of school, averaging 60 students; $2,000, maintenance. (b) Science instructor; 300-bed hospital; California. (c) Nursing arts instructor; large training school; experienced instructor in middle thirties preferred; Virginia. No. 734.

SUPERVISORS—(a) Operating room; 800-bed hospital; must be qualified to carry on teaching program for students, handle administrative duties; salary sufficient to secure best person available. (b) Obstetrical; 50-bed department housed in recently opened building, modernly equipped; degree, teaching ability essential; $125, maintenance; New York. No. 735.

ANESTHETISTS—(a) Relief anesthetist; June-August; $150, maintenance; California. (b) Two anesthetists;; 200-bed hospital; three anesthetists; must be thoroughly experienced, capable administering cyclopropane, also avertine; $100, maintenance; Islands. (c) For county hospital to be opened this month; must be willing to combine with other duties; northern state. No. 739.

Celina, Ohio—Construction on the new addition to the Gibbons Hospital, Celina, Ohio, has been started.

Cincinnati, Ohio—The Catherine Booth Home and Hospital and the Evangeline Booth Home and Hospital, Cincinnati, Ohio, have been merged. **Maj. Marion Kimball,** who has been a director of the Catherine Booth Home and Hospital for fifteen years, will be in charge of the merged institutions.

Cleveland, Ohio—The Lakeside Hospital, Cleveland, Ohio, was left $50,000 by the late Chester C. Bolton, who died in that institution on October 29, 1939.

Clinton, Oklahoma—Construction has been started on a new $100,000 unit to the Western Oklahoma Tuberculosis Sanatorium, Clinton, Oklahoma.

Galion, Ohio—Ralph E. and J. S. Boyd have donated a site for the new City Hospital at Galion, Ohio. The new hospital will cost approximately $100,000.

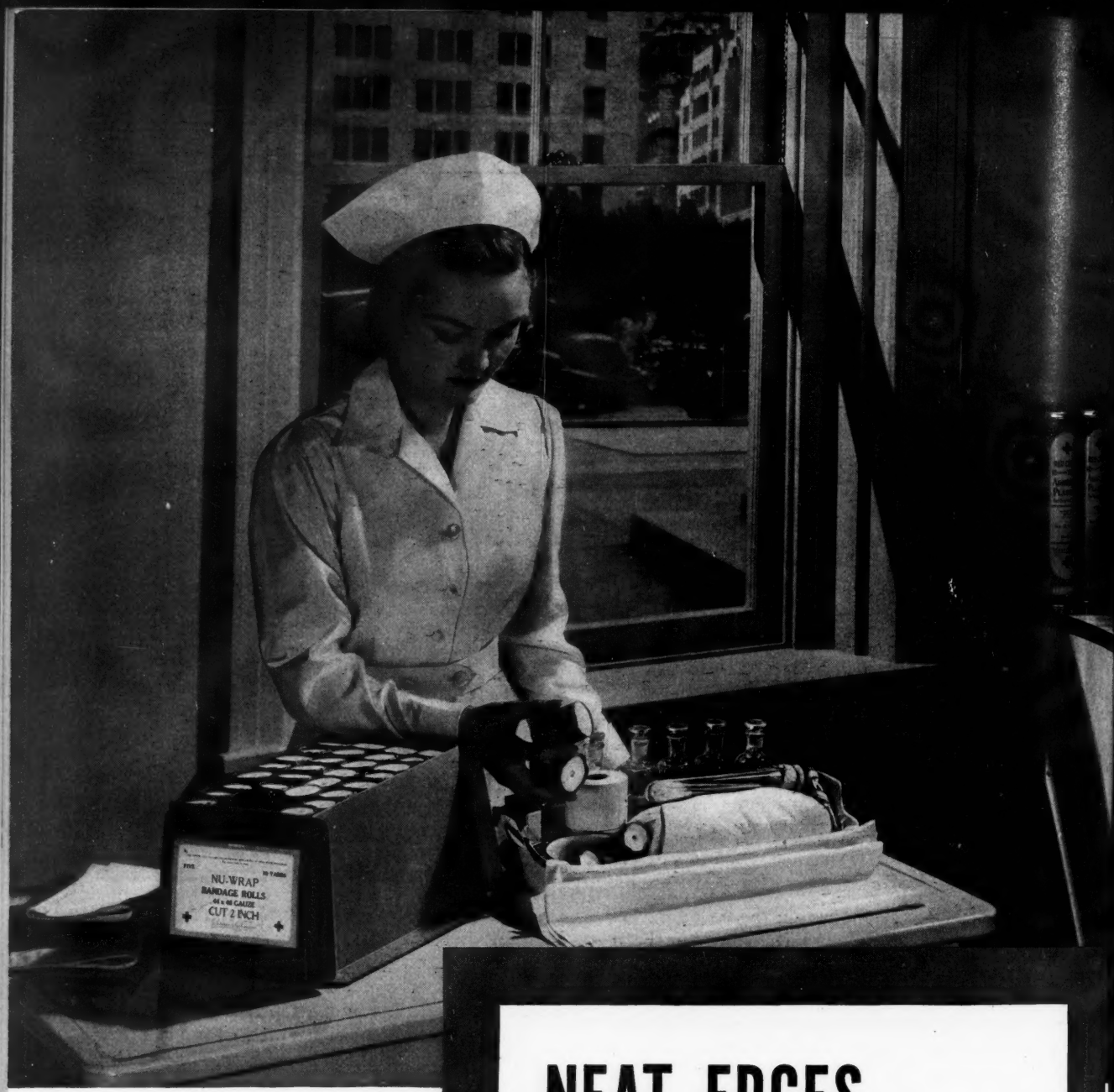
Greenville, Ohio—The Wayne Hospital Company, Greenville, has approved plans for the construction of an addition to cost $60,000.

Reading, Pennsylvania—St. Joseph's Hospital, Reading, Pennsylvania, has recently completed its new construction and has installed a modern iron lung, reputedly the only one in Berks County. The hospital has also installed deep therapy x-ray apparatus, a special isolation unit in the pediatrics department, a special food conveyor, six dressing carts fully equipped in stainless steel, new stainless steel operating room equipment, curtained cubicles in all wards and semi-private rooms, and a modern comptometer in the office.

McKinney, Texas—Construction has started on the addition to the Municipal Hospital at McKinney, Texas. The new addition, which will cost $100,000, will increase the capacity of the hospital to 100 beds.

Marinette, Wisconsin—The Marinette General Hospital, Marinette, Wisconsin, has been completed and will be ready for occupancy about May 1.

Milwaukee, Wisconsin—The Columbia Hospital, Milwaukee, Wisconsin, has raised $200,000 for the construction of a new wing for the accommodation of its maternity department and new laboratories.



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The House of Delegates — 1940

SIXTY members of the House of Delegates of the American Hospital Association have been elected and reported to the executive secretary.

The States of Alabama, California, Iowa, Louisiana, Maryland, Mississippi, Montana and North Dakota, Puerto Rico and the Province of Alberta have held their elections but had not reported the results of the elections at the time *HOSPITALS* went to press.

Arkansas, Indiana, Kentucky, Michigan, Minnesota, New Jersey, Pennsylvania, South Dakota, New Mexico, New York, Washington, Wisconsin, West Virginia, and the Provinces of Ontario and Saskatchewan will hold the election of their delegates the latter part of April and the month of May.

Illinois, Delaware, and Hawaii will set a later date for their election.

Following is a list of the elected delegates:

President ..... Fred G. Carter, M.D.
President-Elect ..... Benjamin W. Black, M.D.
Past-President ..... G. Harvey Agnew, M.D.
Treasurer ..... Asa S. Bacon

Trustees

Term expires 1940:
Christopher G. Parnall, M.D.
Frank J. Walter
Peter D. Ward, M.D.

Term expires 1941:
Ada Belle McCleery
Ellard L. Slack
Donald C. Smelzer, M.D.

Term expires 1942:
Rt. Rev. Msgr. M. F. Griffin
Henry M. Pollock, M.D.
George D. Sheats

Delegates-at-Large

Term expires 1940:
R. H. Bishop, Jr., M.D.
Allan Craig, M.D.
Albert G. Hahn
Robert Jolly
Margaret A. Rogers

Term expires 1941:
A. C. Bachmeyer, M.D.
C. J. Cummings
Eleanor E. Hamilton, R.N.
George F. Stephens, M.D.
Mrs. Jewell W. Thrasher, R.N.

Term expires 1942:
E. M. Bluestone, M.D.
Lee C. Gammill
James A. Hamilton
Rev. Donald A. McGowan
Fred M. Walker

State	Delegate	Alternate
Arizona	J. O. Sexton	
Colorado	Walter G. Christie	Herbert A. Black, M.D.
Connecticut	Wilmar M. Allen, M.D.	Albert W. Buck
District of Columbia	Lewis H. Taylor, M.D.	Ross Garrett
Florida	W. L. Shackelford, M.D.	J. H. Therrell
Georgia	Robert S. Hudgens	Harry W. Smith
Idaho	Jacob H. Trayner	Fred W. Anderson
Kansas	Rev. J. E. Lander	J. R. Stone
Maine	Joelle Hiebert, M.D.	Sister Belanger
Massachusetts	Scott Whitcher	George A. MacIver, M.D.
	Miriam Curtis, R.N.	Clara B. Peck, R.N.
Missouri	Frank Bradley, M.D.	H. J. Mohler
Nebraska	Rev. Emil Chinlund	Francis J. Bean, M.D.
New Hampshire	Donald S. Smith	Anne MacDougall
North Carolina	Newton Fisher	F. Ross Porter
Ohio	M. F. Steele, M.D.	Harry H. Graef
	Guy J. Clark	Mabel F. Pittman
Oklahoma	E. T. Olsen, M.D.	L. E. Emmanuel, M.D.
Oregon	C. H. Manlove, M.D.	
Rhode Island	D. L. Richardson, M.D.	Carl Lindblad
South Carolina	Francis Oliver Bates	H. H. McGill
Tennessee	Henry Hedden, M.D.	C. P. Connell
Texas	Mrs. Josie Roberts	E. M. Collier
	E. M. Dunstan, M.D.	Eva Wallace
Utah	Harold S. Barnes	Mrs. Freda Consigny
Vermont	Katherine M. Crozier, R.N.	Jean Stevens, R.N.
Virginia	Arthur H. Perkins, M.D.	W. N. Walters
Canada		
British Columbia	A. K. Haywood, M.D.	J. H. McVety
Manitoba	G. S. Williams, M.D.	Kathryn M. McLearn
New Brunswick	S. R. D. Hewitt, M.D.	A. J. MacMaster, R.N.
Nova Scotia	E. Graham	George A. McIntosh, M.D.
Quebec	W. H. Delaney, M.D.	C. A. Decary, M.D.

National Hospital Day is a day of hospitality, of friendliness and cordiality. A day when our communities are welcomed within our doors, not as patients but as our personal guests. A day during which the skills of good hospital service are shown to the public who support our institutions. Hospitals have no selfish nor sordid interest in the celebration of this day.

The promotion of good will, the encouragement of better and more permanent relationships, and the cultivation of sympathetic understanding of our hospitals and the service they are constantly rendering to all of our people are our sole objectives in the observance of National Hospital Day.